

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

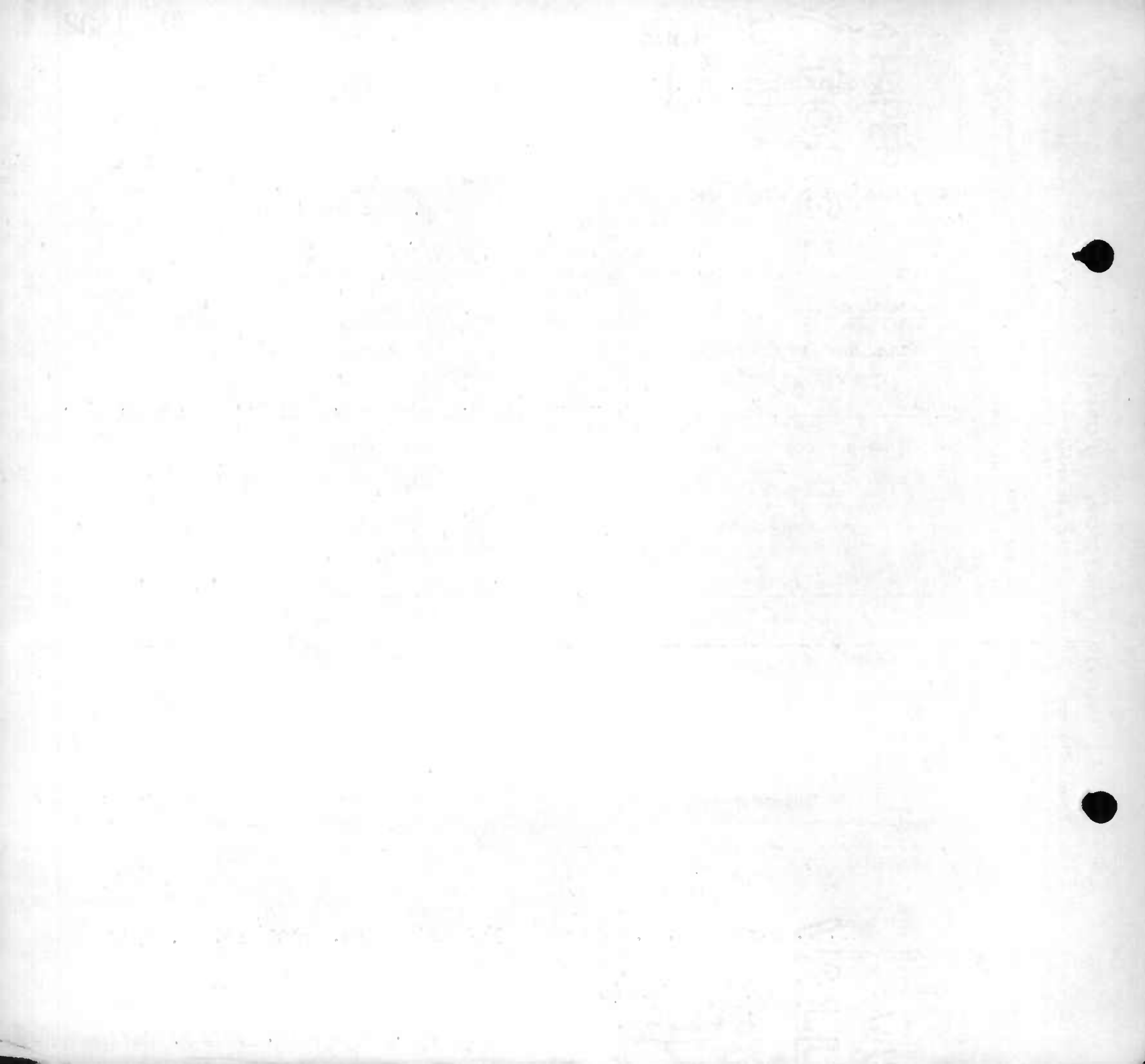
S-520 70 1501		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1501	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WALTER Phillip Schmick		2. DATE AND HOUR OF DEATH FEBRUARY 3, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2631			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5711 PLAINFIELD AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 23, 1912	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHOTO ENGRAVER		10B. KIND OF BUSINESS OR INDUSTRY NEWSPAPER		11. BIRTHPLACE (State or foreign country) BALTO., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WALTER SCHMICK		14. MOTHER'S MAIDEN NAME KATHRYN F. BUSSEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES U.S. NAVY W.W.II		16. SOCIAL SECURITY NO. 213-03-3138		17. INFORMANT WIFE ADDRESS KATHERINE E. (ESCHINSKY) (SAME)	
18. 4-10-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/3/70 4/3/70	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/24/69 19 to 2/3/70 19 that (I) (we) last saw the deceased alive on 11/24/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Walter E. Hargrave MD				23B. DATE SIGNED 2/4/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2-6-1970		24C. NAME OF CEMETERY or CREMATORY BALTO. U.S. NATIONAL CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO., Md		25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Smith	
25C. FUNERAL DIRECTOR J. Walter Gmelin		25D. ADDRESS 5444 BELAIR Rd.			

(Scrub K)

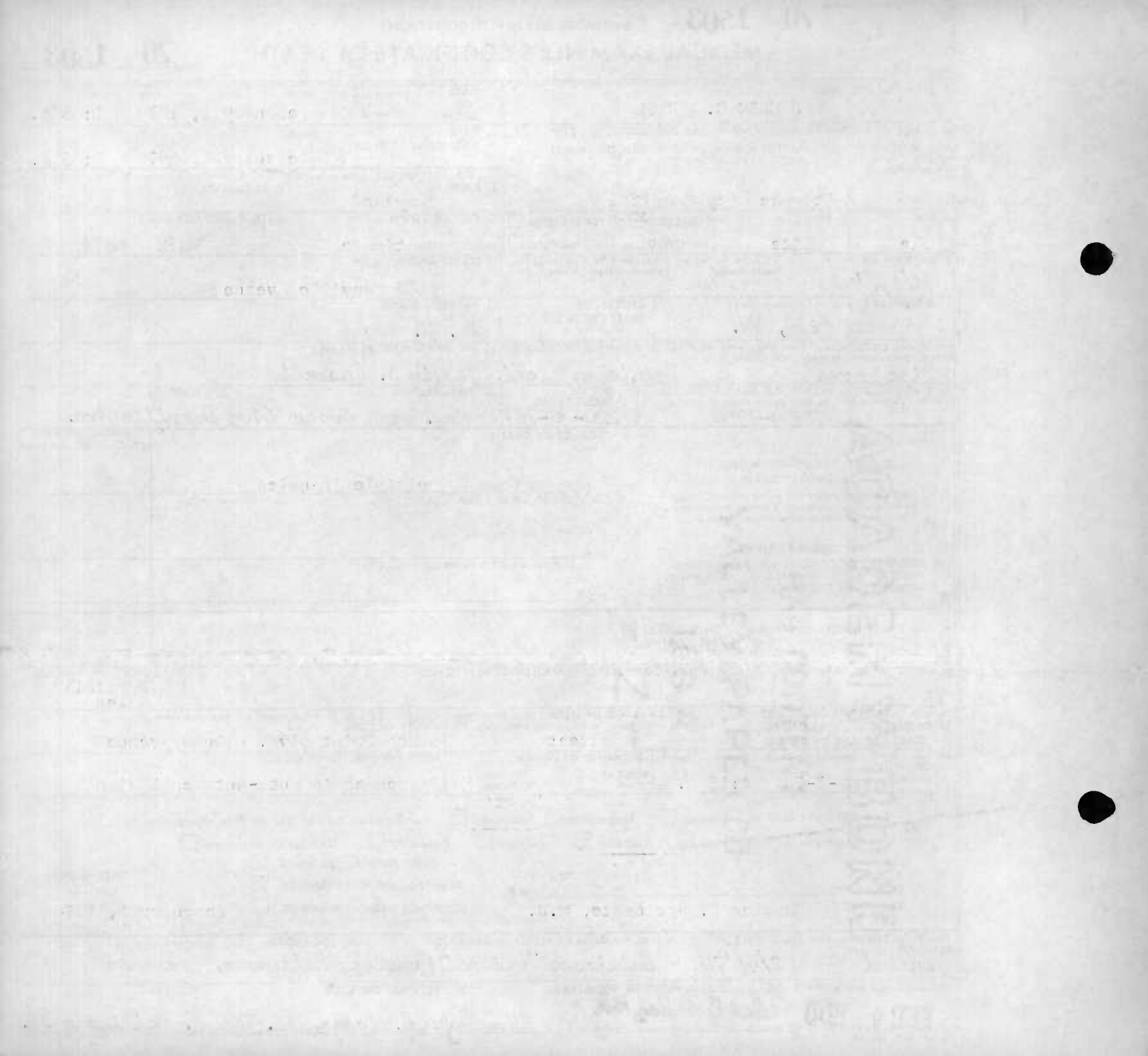
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1502	
<div style="display: flex; justify-content: space-between;"> B-500 70 1502 </div>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Florence A. Baum</i>				2. DATE AND HOUR OF DEATH <i>February 3, 1970</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Gould's Nursing Home</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>601</i>	
				C. CITY OR TOWN <i>Baltimore</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>124 N. Decker Avenue</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/29/'01</i>	9. AGE (In years last birthday) <i>68</i>	10. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
13. FATHER'S NAME <i>Harrison McElderidge</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>276-28-6533</i>		
			17. INFORMANT <i>Mr. William H. Baum</i>		
			ADDRESS <i>5412 Genland Ave.</i>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Heart Failure due to arteriosclerosis</i> <i>Cardio Vascular disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Advanced Cirrhosis Liver</i> (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/27</i> 19 <i>70</i> to <i>2/3</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>2/2</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date <i>2/3</i> 19 <i>70</i> and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>L. B. Stevens</i>				23B. DATE SIGNED <i>2/5/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>L. B. Stevens, M. D.</i>				23D. ADDRESS <i>3400 Erdman Ave. Baltimore, Md. 21213</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/7/'70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 8 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>John A. Morgan, Inc. 3000 E. Baltimore St</i>	



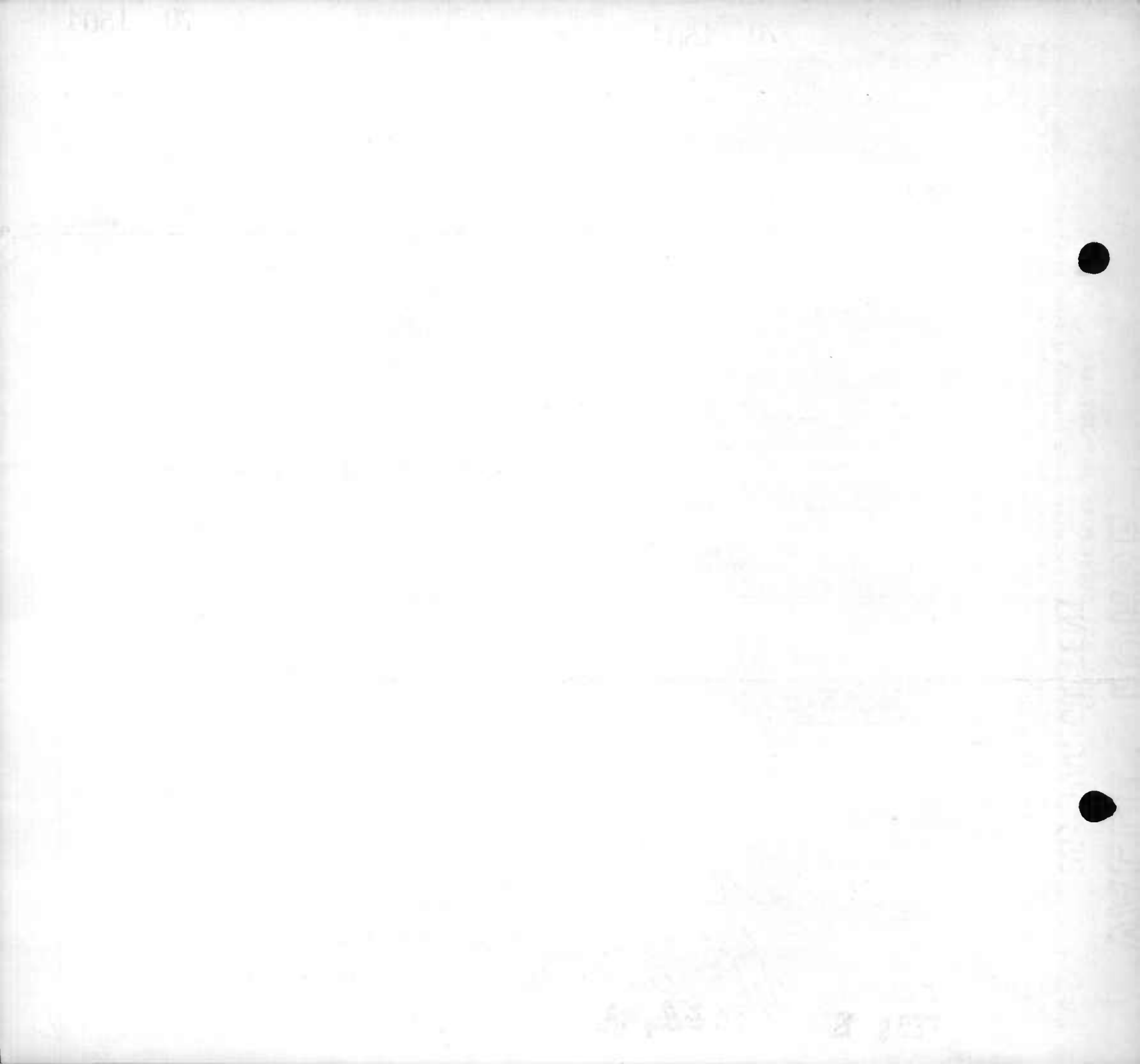
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD	
JACKIE C. MOORE		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
Baltimore City Hospital		Maryland		B. COUNTY	
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)	
8/13/47		28		Scott City, Va.	
12. CITIZEN OF		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
USA		Wm. R. Moore		Pipe Layer	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
Jessie S. Cassell		Yes		220-36-7819	
18. INFORMANT		19. CAUSE OF DEATH		20. DATE OF OPERATION	
Mrs. Joann Moore		Multiple injuries		208. CONDITION FOR WHICH OPERATION WAS PERFORMED	
6105 Danville Ave.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		21. AUTOPSY? (Yes or No)	
		(B) DUE TO, OR AS A CONSEQUENCE OF:		(Partial) Yes	
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
		street		North Point Blvd. & Quad Avenue	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
2-1-70 1:15 A. m.				Passenger in auto-auto collision	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Charles S. Springate, M.D.		Burial		2/4/70	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.	
Baltimore National Cemetery Baltimore, Maryland				FEB 9 1970	
25A. NAME OF REGISTRAR		25B. FUNERAL DIRECTOR		25C. ADDRESS	
Robert E. Taylor		John A. Brown, Inc.		3000 E. Baltimore St.	



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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
K-120 BIRTH NO.		70 1504		70 1504	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Koupas, Nicholas</u>				2. DATE AND HOUR OF DEATH <u>2-3-70</u> <u>11:00</u> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1102</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 MARYLAND GENERAL</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
				D. STREET ADDRESS (If rural, give location) <u>12 W. Biddle ST.</u>	
5. SEX <u>Male</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>?</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>		13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-18-7544</u>		17. INFORMANT <u>PATIENT</u>	
18. <u>433.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRAL THROMBOSIS</u>		CAUSE OF DEATH (A) <u>CEREBRAL THROMBOSIS</u> DUE TO (B) <u>—</u> DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>—</u>		22. I certify that (1) (this hospital) attended the deceased from <u>1-24</u> 19 <u>70</u> to <u>2-3</u> 19 <u>70</u> , that (2) (we) lost saw the deceased alive on <u>2-3</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>C. E. DeFolice</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>2-3-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. E. DeFolice</u>		M.D. <u>BALTIMORE, MD.</u>		23D. ADDRESS <u>BALTIMORE, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/6/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greek Orthodox Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>		25B. NAME OF REGISTRAR <u>Nicholas T. Matthew's</u>	
25C. FUNERAL DIRECTOR <u>303 Eastern Ave., Baltimore, Md.</u>		ADDRESS			



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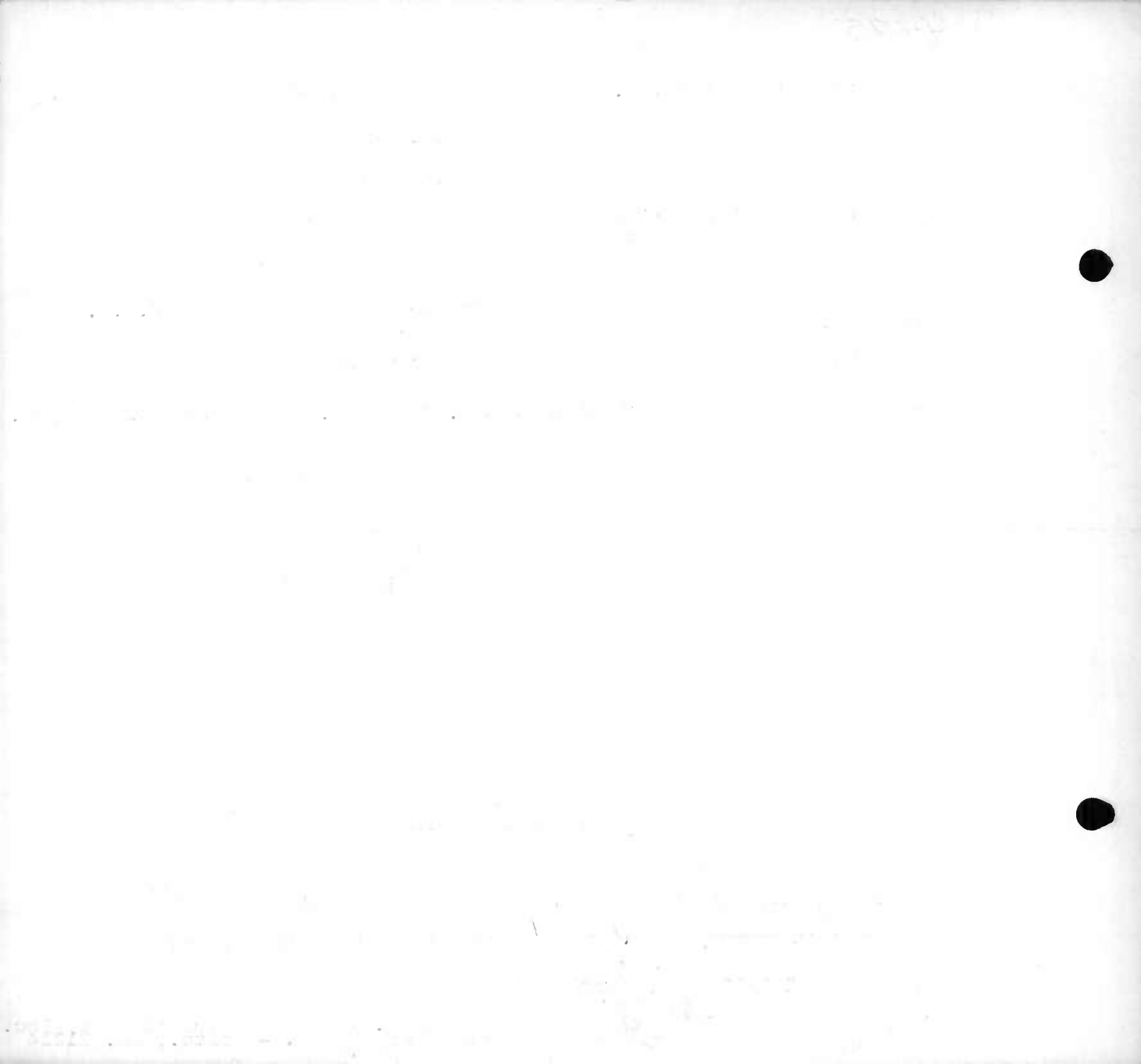
7-520 BIRTH NO.		70 1505		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 70 1505	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ALPHONSA J. THOMAS				2. DATE AND HOUR OF DEATH 2/2/70			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 908 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2208 Kirk Ave.			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/20/1912	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 217-26-9151			17. INFORMANT Mrs. Ruby H. Thomas 2208 Kirk Ave.				
18. 412.2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Myocardial infarction DUE TO coronary disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-15-1964 to 1-29-1970, that (I) (we) last saw the deceased alive on 1-29-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE TURGOT J. J. J.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 2-5-70	
23C. PHYSICIAN'S NAME (Type) TURGOT J. J. J.				23D. ADDRESS M.D. 1249 N. Fulton Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/7/70		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wm. G. March		ADDRESS 928 E. North Ave.	

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FUNERAL DIRECTOR: IMPORTANT

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4-625		70 1506		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1506	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Harrison, Myrtle C.			
2. DATE AND HOUR OF DEATH 2/4/70 4:15 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland 2653				5. SEX Female			
6. RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3/15/91				9. AGE (In years last birthday) 78			
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Home			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George W. Duvall				14. MOTHER'S MAIDEN NAME Ida Christopher			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-10-9729			
17. INFORMANT Rev. Joseph A. Harrison-Greenville, Pa.				ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A). cachexia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/23/70 1970 to 2/4/70 1970 that (I) (we) last saw the deceased alive on 2/4 2:30 AM 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Harvey G. Klein, M.D.			
23B. DATE SIGNED 2/4/70				23C. PHYSICIAN'S NAME (Type) Harvey G. Klein, M.D.			
23D. ADDRESS The Johns Hopkins Hospital				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 2/7/70				24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery			
24D. LOCATION (City, town, or county) (State) Baltimore Maryland				25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970			
25B. NAME OF REGISTRAR Robert C. Altenburg				25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc.			
25D. ADDRESS 5009 Harford Rd. - Balto., Md. 21214				VS 150-REV 1/1/68			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1507			
<div style="display: flex; justify-content: space-between;"> G-651 70 1507 CERTIFICATE OF DEATH </div>							
BIRTH NO. 1. NAME OF DECEASED (Type or Print) George L. Greenfield				2. DATE AND HOUR OF DEATH 2-4-70 11:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines 5837 Belair Rd.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6006 Sefton Ave.			
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/9/84	
				9. AGE (In years last birthday) 85		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY Truck Dispatcher		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Greenfield				14. MOTHER'S MAIDEN NAME Susan Gordon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-03-9417		17. INFORMANT ADDRESS Mrs. Evelyn Evans - 6005 Burgess Ave.	
18. CAUSE OF DEATH <div style="display: flex;"> <div style="flex: 1;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="flex: 1;"> (A) IMMEDIATE CAUSE <u>Cancer prostate</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ </div> <div style="flex: 0.5; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> </div> </div>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>Feb. 4, 1970</u>, that (I) (we) last saw the deceased alive on <u>FEB. 3, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R. Donald Jandorf</u> DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 2/6/70	
23C. PHYSICIAN'S NAME (Type) R. Donald Jandorf, M.D.				23D. ADDRESS 7403 Harford Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/7/70		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970				25C. FUNERAL DIRECTOR ADDRESS Robert C. Altenburg Funeral Home Inc. 6009 Harford Rd. - Balto., Md. 21214			

AT 1117

George L. ...

Home in the ...

2677 ...

with ...

... ..

Philip ...

Susan ...

... ..

... ..

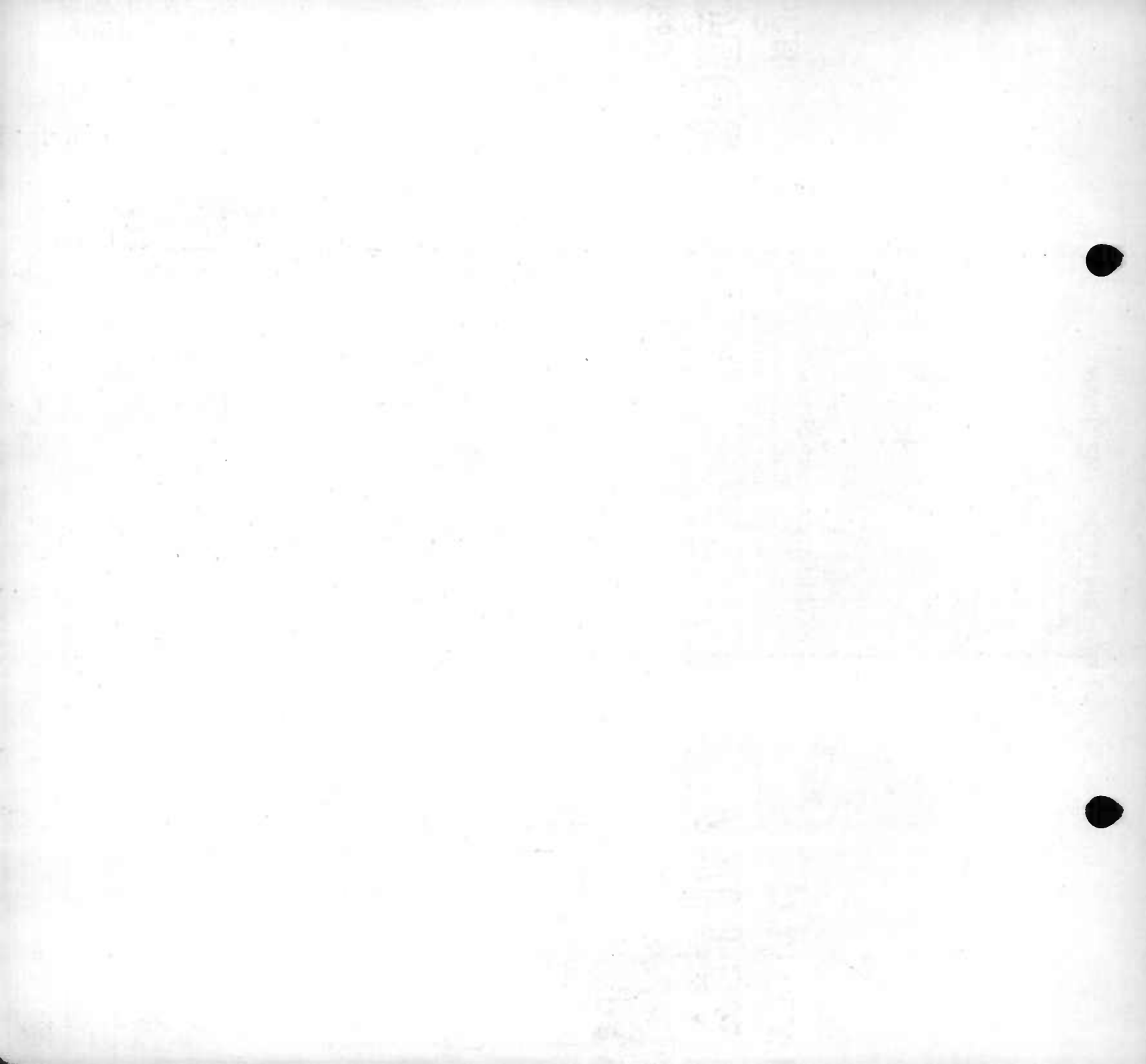
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1508	
R-123 70 1508 CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) <i>Re. block, Mary</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>43 S B G H</i>		2. DATE AND HOUR OF DEATH <i>2-6-70 6:25 pm</i>			
4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore City</i>		5. SEX <i>F</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>6-27-88</i>		9. AGE (In years lost birthday) <i>81</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Va</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Dec Wm. Currier</i>			
14. MOTHER'S MAIDEN NAME <i>Harriet Martin</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family June</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>congestive heart failure</i> (B) <i>coronary atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i> <i>years</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>K. J. Hammerstein, M.D.</i>				23B. DATE SIGNED <i>2/6/70</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>2-10-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Catholic</i>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR			
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR		25C. ADDRESS <i>130 E. Fort St</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-550		70 1509		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1509	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) WALTON COWMAN				2/5/70 6:35P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) GOOD SAMARITAN HOSPITAL 5601 Loch Raven Blvd				A. STATE MARYLAND , B. COUNTY Baltimore C. CITY OR TOWN Baltimore , D. INSIDE CITY LIMITS? 2802 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5622 Stonington Ave			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/05	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: XX XX	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claims Adjustor			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Cowman			14. MOTHER'S MAIDEN NAME JULIET VANSANT				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Army WW11			16. SOCIAL SECURITY NO. 216 010874		17. INFORMANT Marion H. Cowman-5622 Stonington Ave #7		
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Empty stomach ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Conjunctive Heart Failure				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Empty stomach (B) DUE TO, OR AS A CONSEQUENCE OF: Conjunctive Heart Failure (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs 1 yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) this hospital attended the deceased from 1/28 19 70 to 2/5 19 70 , that I last saw the deceased alive on 2/5 19 70 and that in my our opinion death occurred on the date and hour and from the causes stated above I we (did) (did not) view the body after death.							
23A. SIGNATURE Wm. W. Lukensmeyer M.D.				23B. DATE SIGNED 2/5/70		23C. PHYSICIAN'S NAME (Type) Wm. W. Lukensmeyer M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-70		24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970				25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Armstrong Funeral Chapel 4600 Liberty Hts.	

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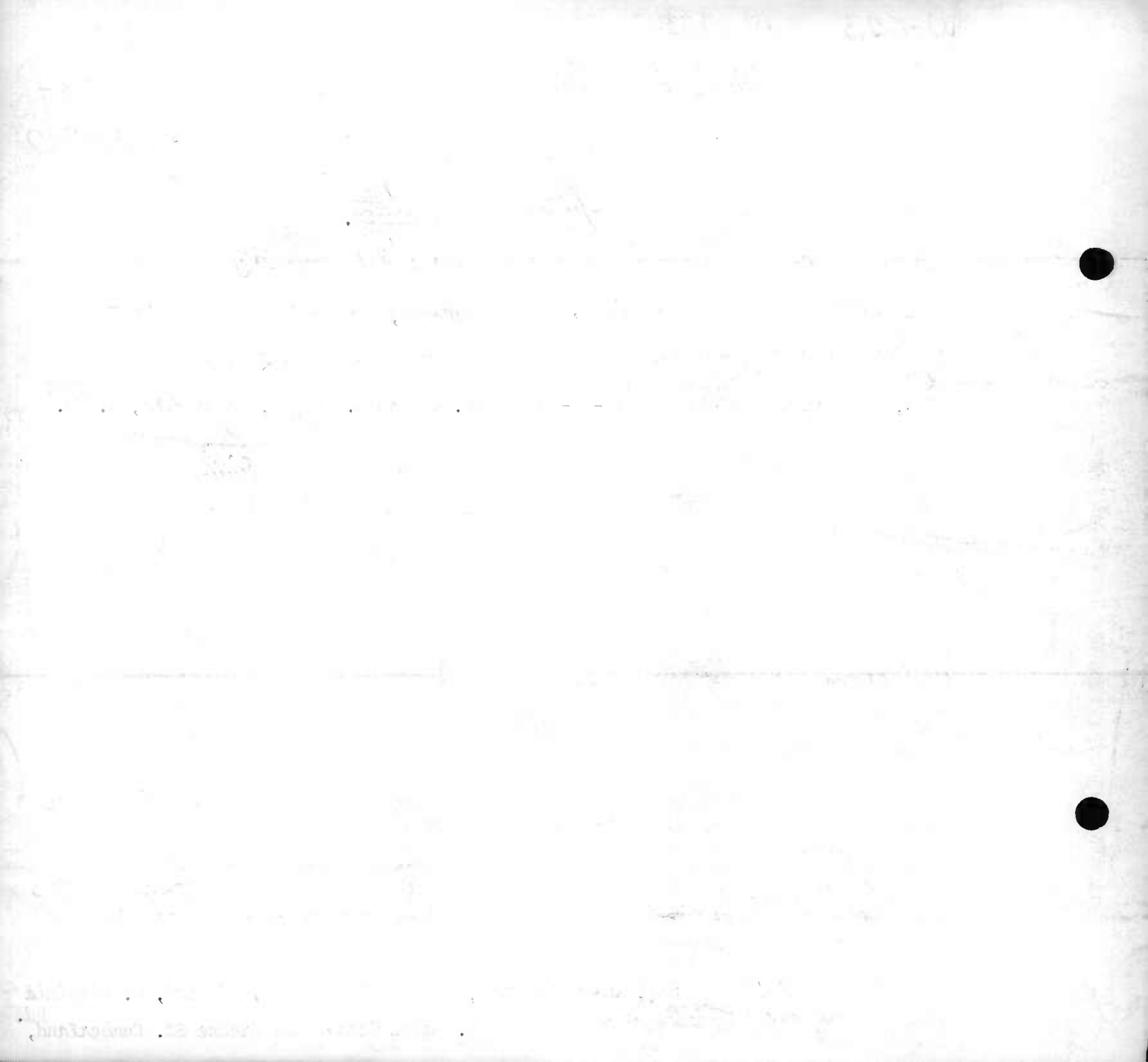
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

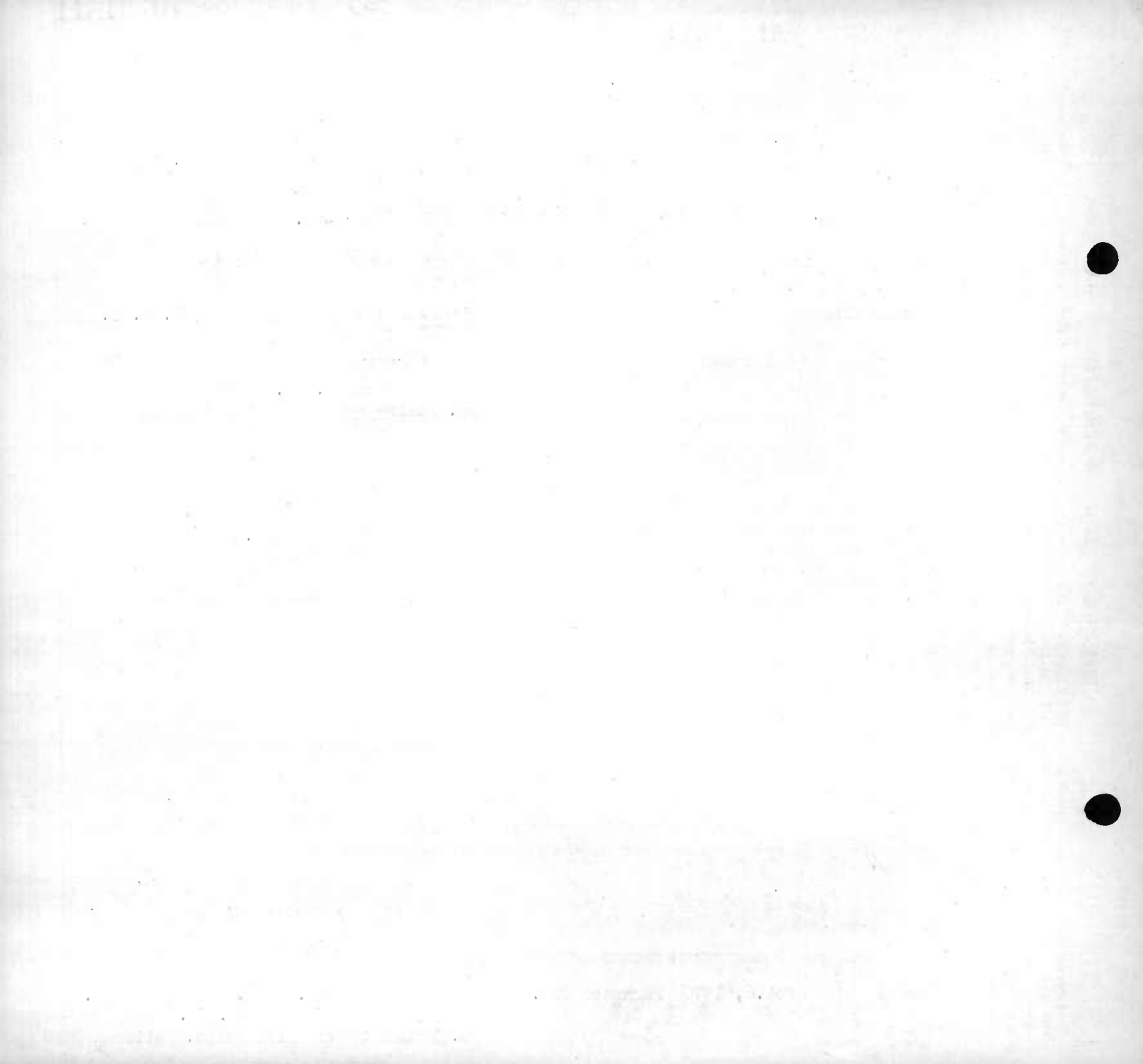
W-623		70 1510		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 1510						
BIRTH NO.					1. NAME OF DECEASED (Type or Print) DAVID GRANT WRIGHT <i>David D. Wright</i>					2. DATE AND HOUR OF DEATH <i>Feb. 2 1970 7:30 A.M.</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY <i>Wiley Ford, West Va. 26767</i>					C. CITY OR TOWN <i>Wiley Ford</i>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University of Maryland Hospital</i>					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					E. STREET AND NUMBER <i>State St.</i>				
5. SEX <i>Male</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/23/31</i>		9. AGE (In years last birthday) <i>38</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Electrical</i>					11. BIRTHPLACE (State or foreign country) <i>McCoolle, Maryland</i>				
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					13. FATHER'S NAME <i>HARRY WRIGHT (dec)</i>					14. MOTHER'S MAIDEN NAME <i>THELMA HARRISON</i>				
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes, Korean Conflict</i>					16. SOCIAL SECURITY NO. <i>217-28-7695</i>					17. INFORMANT <i>Mrs. Lenora K. Wright, Wiley Ford, W. Va.</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>747.2 I</i>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral aneurysm of sinus of valvula; Ruptured?</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF:					(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).														
19A. DATE OF OPERATION <i>None</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>Yes</i>				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from <i>January 30 1970</i> to <i>Feb. 2 1970</i> that (I) (we) last saw the deceased alive on <i>Feb. 2 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					23A. SIGNATURE <i>V. Hernandez</i>				
23B. DATE SIGNED <i>Feb 2/70</i>					23C. PHYSICIAN'S NAME (Type) <i>Vicente Hernandez</i>					23D. ADDRESS <i>6 of Maryland Hospital Bldg 21201 Mel</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>2/5/70</i>					24C. NAME of CEMETERY or CREMATORY <i>Fort Ashby Cemetery</i>				
24D. LOCATION (City, town, or county) (State) <i>Fort Ashby, Mineral, W. Virginia</i>					25A. DATE REC'D BY HEALTH DEPT. <i>FEB 9 1970</i>					25B. NAME OF REGISTRAR <i>Robert E. ...</i>				
25C. FUNERAL DIRECTOR <i>H. Wayne Bodge</i>					ADDRESS <i>202 Greene St. Cumberland, Md.</i>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1511	
E-600 70 1511		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MAGDELINE EURY		2. DATE AND HOUR OF DEATH 2-3-70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNION MEMORIAL HOSP. 133rd AND CALVERT STREETS		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN BALTO MD D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4307 Furley Ave.	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-84 9. AGE (In years lost birthday) 85 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) GERMANY
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Balto. Md. 21205 ADDRESS Mrs. Claire Pyle 1242 Armistead Way
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)..... APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 40 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8 Dec 19 69 to 3 Feb 19 70 , that (I) (we) last saw the deceased alive on 31 Dec 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jones M. Brown, M.D. DEGREE		23B. DATE SIGNED 4 Feb 70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 3925 BEECH AVE BALTIMORE MD 21211	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb. 6, 1970	24C. NAME OF CEMETERY or CREMATORY Parkwood Cem.	24D. LOCATION (City, town, or county) (State) Balto. Co. Md.
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Kelly	
25C. FUNERAL DIRECTOR G. Truman Schwab		25D. ADDRESS Balto. Md. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-536 70 1512		BALTIMORE CITY HEALTH DEPARTMENT		70 1512	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>JOHN HUNTER</u>		2. DATE AND HOUR OF DEATH <u>2-7-70</u> <u>3 15</u> A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>T</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>520 ST. PAUL ST.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/00</u>	9. AGE (In years last birthday) <u>70</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARETAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>FLORIDA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN HUNTER</u>		14. MOTHER'S MAIDEN NAME <u>ELEANOR HENRY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>218-10-2826</u>		17. INFORMANT <u>L. HUNTER</u> ADDRESS <u>ABOVE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>410.401-250.9</u> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <u>22.2. bronchopneumonia</u> <u>Acute Myocardial Inf.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD, Diabetes</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> <u>70</u> to <u>2/7</u> <u>70</u> that (I) (we) last saw the deceased alive on <u>2/6</u> <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. Shuman</u>		23B. DATE SIGNED <u>2/7/70</u>		23C. PHYSICIAN'S NAME (Type) <u>W. Shuman</u>	
23D. ADDRESS <u>MERCY HOSP</u>		23E. DEGREE <u>MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>2/9/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>GOOD SHEPARD</u>	
24D. LOCATION <u>DANIELS MD, 300</u>		24E. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>			
24F. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		24G. FUNERAL DIRECTOR <u>Conrad E. Turner</u>		24H. ADDRESS <u>1102</u>	

Handwritten notes, possibly a list or index, with some legible words like "page" and "1000-1000".

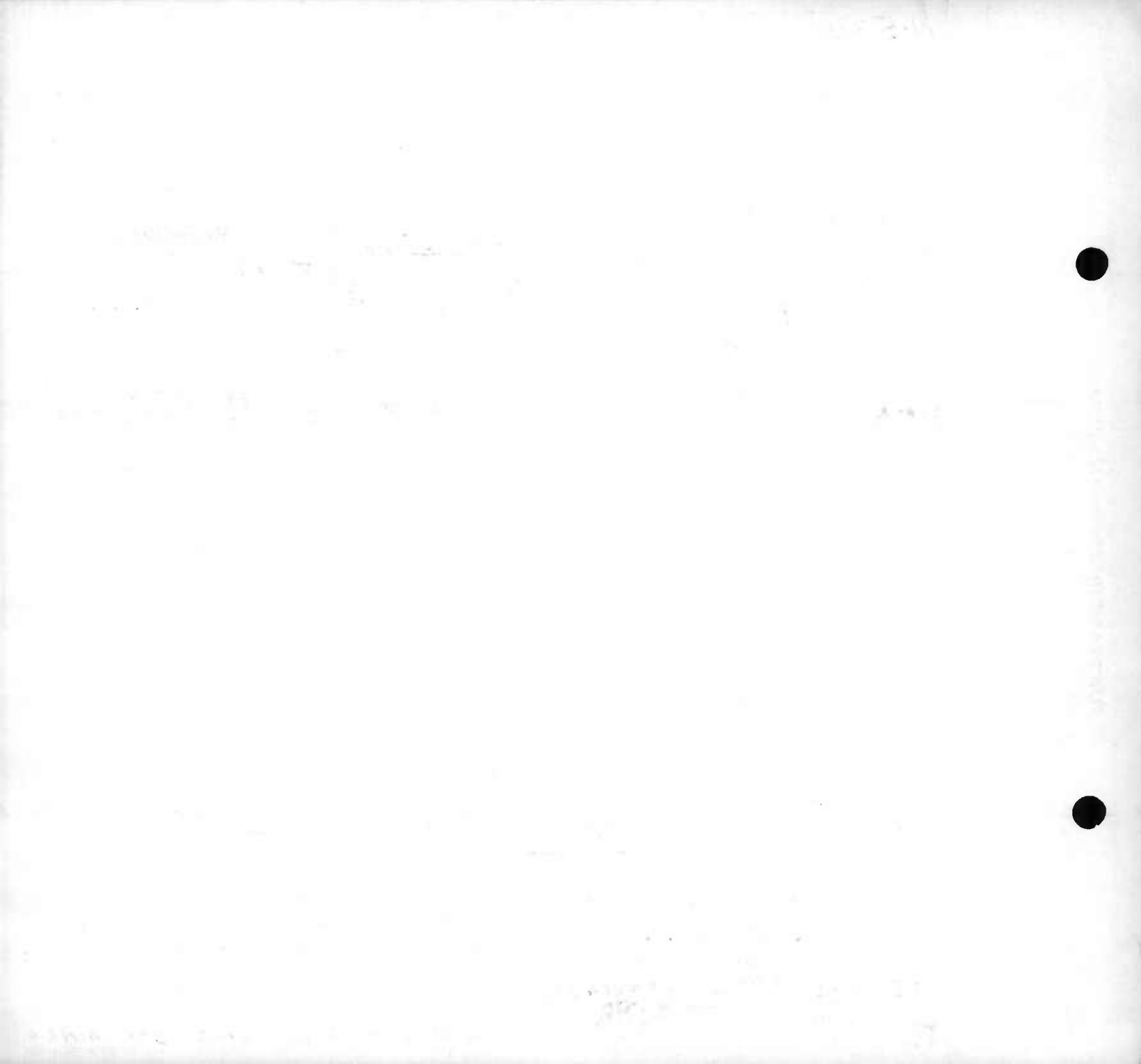
Handwritten word, possibly "and".

Handwritten notes at the bottom of the page, including a small sketch of a curved line.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

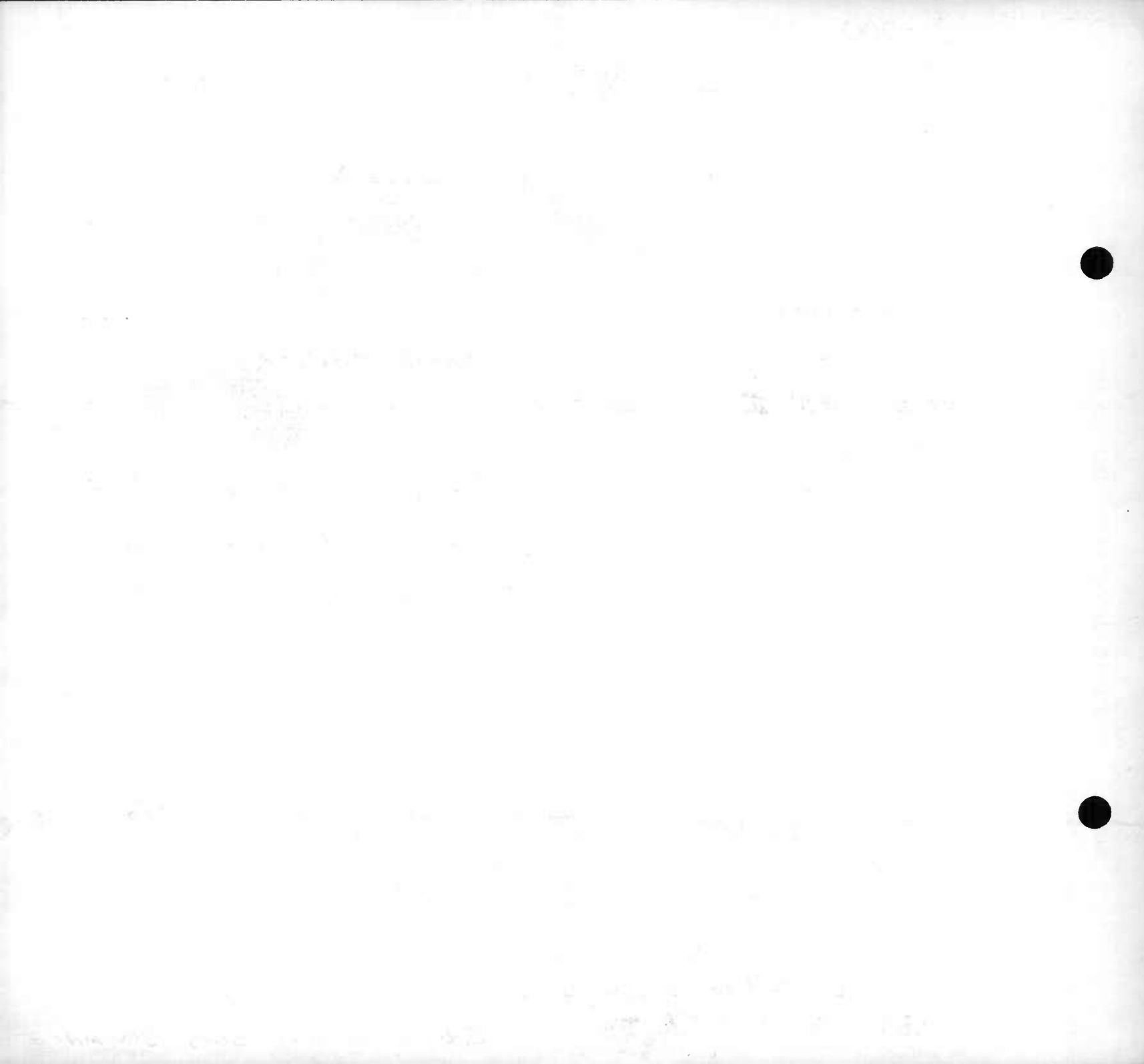
M-532		70 1513		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 1513	
1. NAME OF DECEASED (Type or Print) REGINA MONTAGUE				2. DATE AND HOUR OF DEATH 2/6/70 1:15 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 1940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2664 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2502 E. Fairmount Avenue 21224			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-8-21 00		9. AGE (In years lost birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO.		17. INFORMANT BCH: Records 4940 Eastern Avenue Baltimore, Maryland 21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PULMONARY EMBOLUS MYOCARDIAL INFARCTION				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 1 WEEK 2 WEEKS			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 1/23 19 70 to 2/6 19 70 that (we) last saw the deceased alive on 2/6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dennis W. Bleakley MD				23B. DATE SIGNED 2/6/70		23C. PHYSICIAN'S NAME (Type) Dennis W. Bleakley M.D.	
23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland							
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 2/10/70		24C. NAME of CEMETERY or CREMATORY LONDONERRY		24D. LOCATION (City, town, or county) (State) CHILLICOTHE OHIO	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970				25C. FUNERAL DIRECTOR J. J. S. CONNELLY SONS 300 MACE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200 70 1514		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WILLIAM BUECHE GEECHE		2. DATE AND HOUR OF DEATH FEB. 5, 1970 1:50AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals		C. CITY OR TOWN ESSE X D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14940 Eastern Avenue Baltimore, Maryland 21224		E. STREET AND NUMBER 1107 Tace Drive 21221 (Apt. 2 B)	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-08
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISTILLER		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 61
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Sr.		14. MOTHER'S MAIDEN NAME SAVIE TAYLOR	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 218-07-3202	
17. INFORMANT BCH: Records Baltimore, Maryland		ADDRESS 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.0 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Upper gastrointestinal hemorrhage	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) Common bile duct obstruction (C) Melastoma (Carcinoma of Foregut) Colon	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-31 to 2-5 19 70 and that (I) (we) last saw the deceased alive on 2-5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Charles D. Lennan		23B. DATE SIGNED 2/5/70	
23C. PHYSICIAN'S NAME (Type) Arnold I. Levinson		23D. ADDRESS Baltimore City Hospitals 21224 4940 Eastern Avenue Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 2/9/70	24C. NAME OF CEMETERY OR CREMATORY HOLLY HILL	24D. LOCATION (City, town, or county) (State) BALTO. MD
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR JOSEPH J. CONNELLY	
25C. FUNERAL DIRECTOR JOSEPH J. CONNELLY		ADDRESS 300 MACE	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

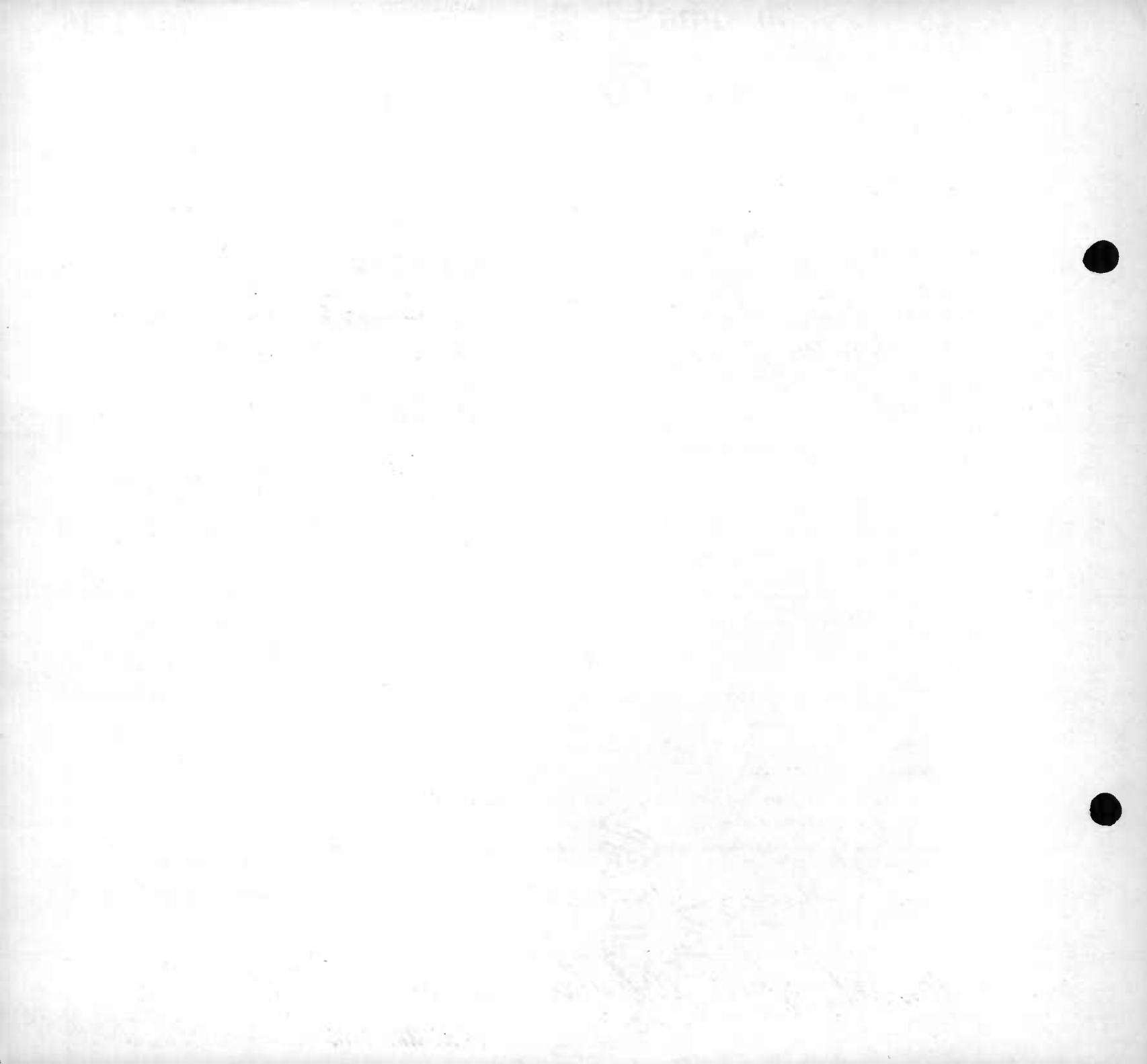
BIRTH NO. B-653		70 1515		BALTIMORE CITY HEALTH DEPARTMENT		X 70 1515	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) Bryant, Wilberth, Henry				2. DATE AND HOUR OF DEATH February 4, 1970, 7:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS				A. STATE Maryland B. COUNTY Baltimore			
ADDRESS OR LOCATION 4940 Eastern Avenue				C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Baltimore, Maryland 21224				E. STREET AND NUMBER 2239 Vailthorn Road 21220			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-28-93	9. AGE (in years lost birthday) 36	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PATERN MAKER			10B. KIND OF BUSINESS OR INDUSTRY M.D.		11. BIRTHPLACE (State or foreign country)		
13. FATHER'S NAME Louis			14. MOTHER'S MAIDEN NAME LAURA SCHOLK				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK			16. SOCIAL SECURITY NO. 705-09-8068		17. INFORMANT ADDRESS 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pneumonia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) ASCVD.			
II				HBP			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from January 16, 1970 to February 4, 1970 that (1) (we) last saw the deceased alive on Feb. 4, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francisco Tejada M.D.				23B. DATE SIGNED February 4, 1970		23C. PHYSICIAN'S NAME (Type) FRANCISCO TEJADA M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2/7/70		24C. NAME OF CEMETERY or CREMATORY MORELANDS		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Russ E. [illegible]		25C. FUNERAL DIRECTOR T.O. SONNALLY SONS		ADDRESS 300 MALE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-320 70 1516				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1516	
1. NAME OF DECEASED (Type or Print) MILDRED WOODS				2. DATE AND HOUR OF DEATH 2/6/70 830 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 1802			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1007 W Fayette 21223			
5. SEX F	6. RACE W N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/6/26		9. AGE (In years lost birthday) 44	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaper		10B. KIND OF BUSINESS OR INDUSTRY USA GOVT		11. BIRTHPLACE (State or foreign country) Balti Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Woods				14. MOTHER'S MAIDEN NAME HATTIE Deshields			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hattie Logan 327 S. Fremont Ave			
18. 4-12-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Ischemic heart disease HAS CUT ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ischemic heart disease Hematomas (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/5 19 70 to 2/6 19 70 , that (I) (we) last saw the deceased alive on 2/6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sandra Z. Salen				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 2/6/70	
23C. PHYSICIAN'S NAME (Type) Sandra Z. Salen, MD				23D. ADDRESS Univ Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2/6/70		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR WILLIAM FINE		25C. FUNERAL DIRECTOR William Fine		ADDRESS 3199 Schomberg St	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1517

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD MILES

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ 2 6 70 7:45 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital D.O.A.

3. DATE PRONOUNCED DEAD Month Day Year Hour
February 6, 1970 7:45 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY 806

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

10-10-40

10. AGE (In years last birthday)

28-29

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1743 N. Washington St.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

WHAT COUNTRY? U.S.

13. FATHER'S NAME

James Walter Sr.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Driver

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Leola Booker

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

217-38-9447

18. INFORMANT

Leola Mason

ADDRESS

613 E. 41st St.

19.

E 890 X I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Conflagration
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

1743 N. Washington St. 806

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

2 6 70 ? m.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject in house fire

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

2-10-70

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Arbutus Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FEB 9 1971

WILLIAM J. SPIER

916 E. North Ave

2/16/70 - Correction form from funeral director.

ABC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> C-414 70 1518 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>70 1518</u>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Mary A. Cleveland</u> <u>MARY A. CLEVELAND</u>		2. DATE AND HOUR OF DEATH <u>2-6-70</u> <u>2:45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME AND HOSPITAL</u> <u>Church Home & Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> & COUNTY <u>Baltimore Co</u> C. CITY OR TOWN <u>Edgemere</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2915 Sparrows Point Road</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-96</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A. AMERICA.</u>		13. FATHER'S NAME <u>HARRY Mc CADDEN</u>			
14. MOTHER'S MAIDEN NAME <u>Frances F. Dennis</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>217-22-5521</u>		17. INFORMANT (Son) <u>Mr. Morgan Cleveland, 2424 Keyway Dundalk, Md. 21222</u>			
18. CAUSE OF DEATH <u>1621 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>METASTATIC CARCINOMA OF LUNGS</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) <u>PROBABLE BRONCHOGENIC CARCINOMA.</u>		<u>3-6 MONTHS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PNEUMOTHORAX, BONE METASTASIS</u>					
19A. DATE OF OPERATION <u>12-30-69 & 1-7-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SCALPENE NOSE & BIOPSY OF RIB.</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month () 1 Day () 1 Year () 1 Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>she</u> (this hospital) attended the deceased from <u>DEC-15</u> 19 <u>69</u> to <u>FEB-6</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>FEB-6</u> 19 <u>70</u> and that (in <u>my</u>) (our) opinion death occurred on the date and hour and from the causes stated above. <u>US</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cegan A. Lopez MD</u>		23B. DATE SIGNED <u>2-6-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Cegan A. Lopez MD</u>	
23D. ADDRESS <u>CHURCH HOME & HOSP.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/9/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>		25B. NAME of REGISTRAR <u>Robert E. Jones</u>		25C. FUNERAL DIRECTOR <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>	

53

12-13-44

100-2200

100-2200

100-2200

100-2200

100-2200

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100-2200

100-2200

100-2200

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100-2200

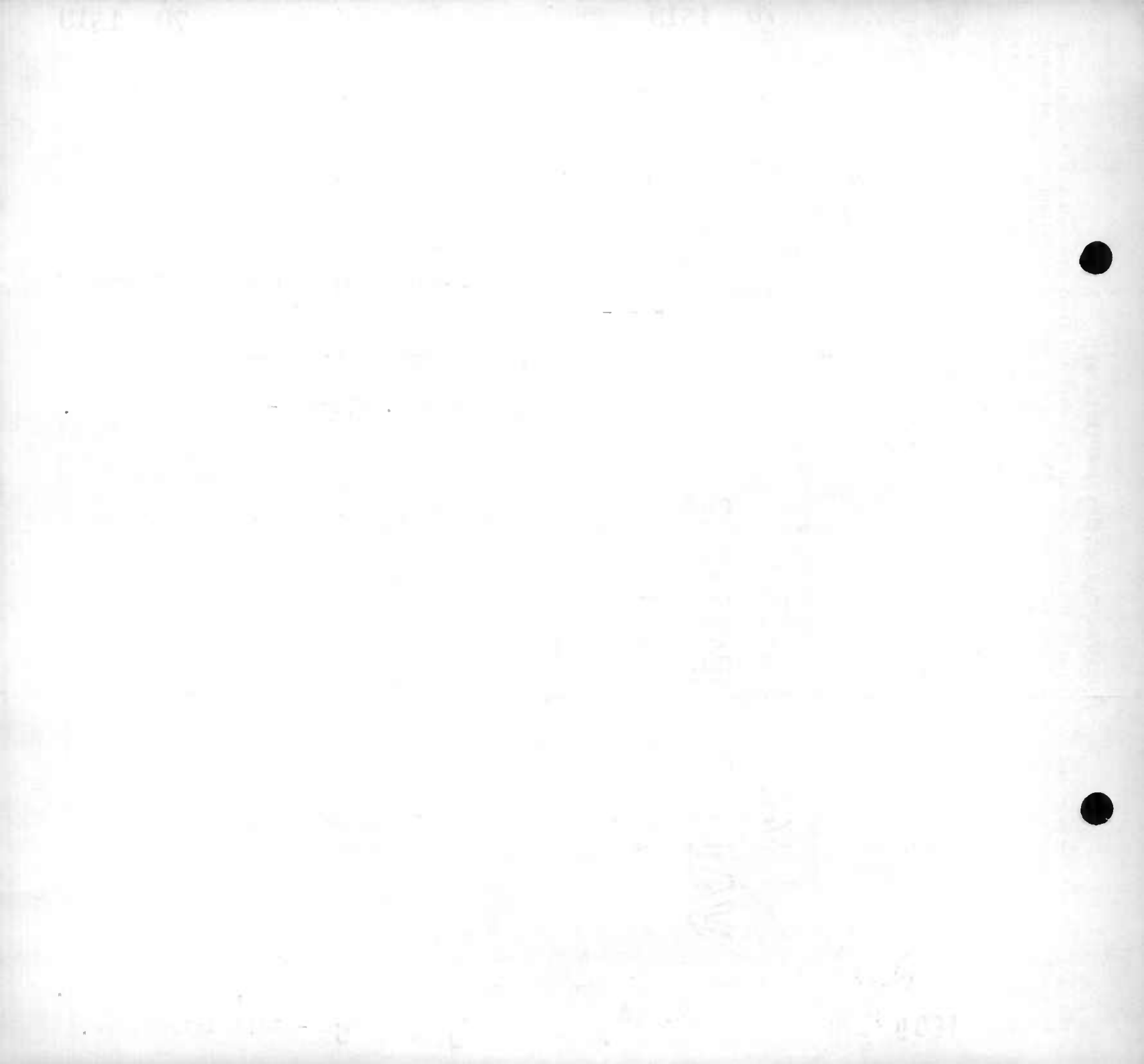
100-2200

100-2200

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

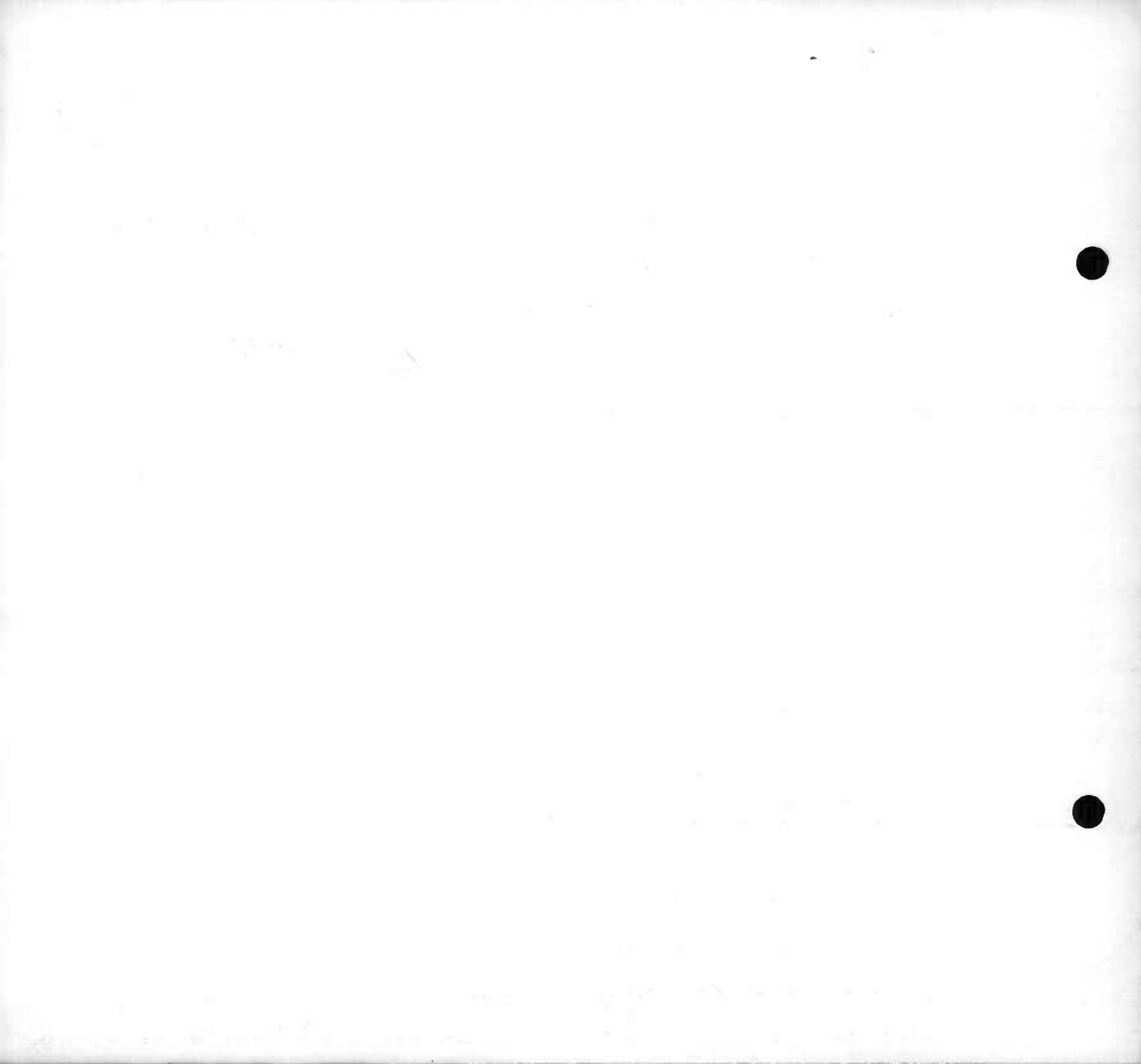
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 1519	
BIRTH NO. 0-416 70 1519		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Oliver, Mrs Myrtle		2/5/1970 8³⁰ pm. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital 48		A. STATE MD. B. COUNTY 1348	
5. SEX Fe.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
6. RACE Ch.		D. STREET ADDRESS (If rural, give location) 1322 Weldon Ave.	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 11/25/07	
9. AGE (In years last birthday) 62		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY - - -		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Phillips Hoover		14. MOTHER'S MAIDEN NAME Laura Meyles	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-7054	
17. INFORMANT James F. Oliver -1322 Weldon Ave.		ADDRESS	
18. 183.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Advanced Carcinoma of ovary		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-11-70 19 to 2-5-70 19 70, that (I) (we) lost saw the deceased alive on 2-5-70 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE U. Sangkum		23B. DATE SIGNED 2-5-70	
23C. PHYSICIAN'S NAME (Type) U. SANGKUM		23D. ADDRESS M.G.H.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/9/70	
24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Ann Donovan	
25C. FUNERAL DIRECTOR Ann Donovan		ADDRESS 3818 Roland Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1520	
G-620 70 1520		CERTIFICATE OF DEATH X			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MATHIE OPAL GROSE		2-4-70 3:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital 43			A. STATE Maryland		
			B. COUNTY Anne Arundel 152-00		
C. CITY OR TOWN Glen Burnie			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER Box 470 Rt. 2 (PINE PLEASANT)					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-1891	9. AGE (In years last birthday) 88 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN-HOME		11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Geraldine Waint (decd.)			14. MOTHER'S MAIDEN NAME Louella M. VANEY (decd.)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Lutba Ketchum (daughter) Same	
18. 269.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Previous malnutrition + dehydration DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-17 1970 to 2-4 1970 that (I) (we) last saw the deceased alive on 3:05 P.M. 2-4 1970 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Virginia J. Faust, M.D.				23B. DATE SIGNED 2-4-70	
23C. PHYSICIAN'S NAME (Type) VIRGINIA J. FAUST, M.D.				23D. ADDRESS South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2-7-70		24C. NAME OF CEMETERY or CREMATORY HINER CEMETERY	
24D. LOCATION Burial		24E. LOCATION Linn, W. Virginia		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR R. E. Miller, M.D.		25C. FUNERAL DIRECTOR S. B. Fleming	
				ADDRESS Glen Burnie, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-655 70 1521		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1521	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Lillie Carman</i>			2. DATE AND HOUR OF DEATH <i>January 31, 1970</i> <i>6 15 P</i> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>City</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Harbor View Nursing Home</i> <i>90 1213 Regatt St</i>			C. CITY OR TOWN <i>Belts</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>4210 Vermont Ave</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/25/88</i>	9. AGE (In years last birthday) <i>81</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Seamstress</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Richmond Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Newton</i>			14. MOTHER'S MAIDEN NAME <i>Susan Kunnally</i>		
15. War Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-03-0909</i>	17. INFORMANT <i>Daughter</i> ADDRESS <i>4210 Vermont Ave</i>		
18. <i>250.9 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Left Hemiplegia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i>
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary embolism</i>		(C) DUE TO, OR AS A CONSEQUENCE OF: <i>arterio-sclerotic heart disease</i>		<i>years</i> <i>years</i>	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> 19 <i>70</i> to <i>1/31</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>1/31</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>al Martin</i>			23B. DATE SIGNED <i>2/1/70</i>		23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MARY NO</i>
23D. ADDRESS <i>2 E Pearl St Belts MD</i>			23E. DEGREE <i>MD</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/4/70</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. DATE REC'D BY HEALTH DEPT. <i>FEB 9 1970</i>			
24F. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		24G. NAME OF REGISTRAR <i>0 0</i>		24H. FUNERAL DIRECTOR <i>Edward J. Ruck, Inc. Baltimore, Md.</i>	



1

M-214 70 1522

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 1522

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARLEE C. McFALLS

2. DATE OF DEATH Known ☐ Month Day Year Hour Estimated ☐ M.

3. DATE PRONOUNCED DEAD Month Day Year Hour February 3, 1970 11:10 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2778

6. SEX Female 7. RACE White 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH March 25, 1926 10. AGE (In years lost birthday) 43 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

11. BIRTHPLACE (State or foreign country) North Carolina 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Edgar J Childres

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 14B. KIND OF BUSINESS OR INDUSTRY 15. MOTHER'S MAIDEN NAME Judy M Reese

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 17. SOCIAL SECURITY NO 243-28-9820 18. INFORMANT Mr Thomas J McFalls ADDRESS Same

19. CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Epilepsy

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 5621 Govans Avenue

22D. TIME (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? Unk.

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE [Signature] M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 2/4/70

EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 2/7/70 24C. NAME of CEMETERY or CREMATORY Kannapolis 24D. LOCATION (City, town, or county) (State) Kannapolis, North Carolina

25A. DATE REC'D BY HEALTH DEPT. FEB 8 1970 25B. NAME OF REGISTRAR [Signature] 25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc. Baltimore, Maryland

VS 151-REV. 1/1/68

ACADEMY BOND

CONTENT

VALLEY PAPER CO

U.S. A

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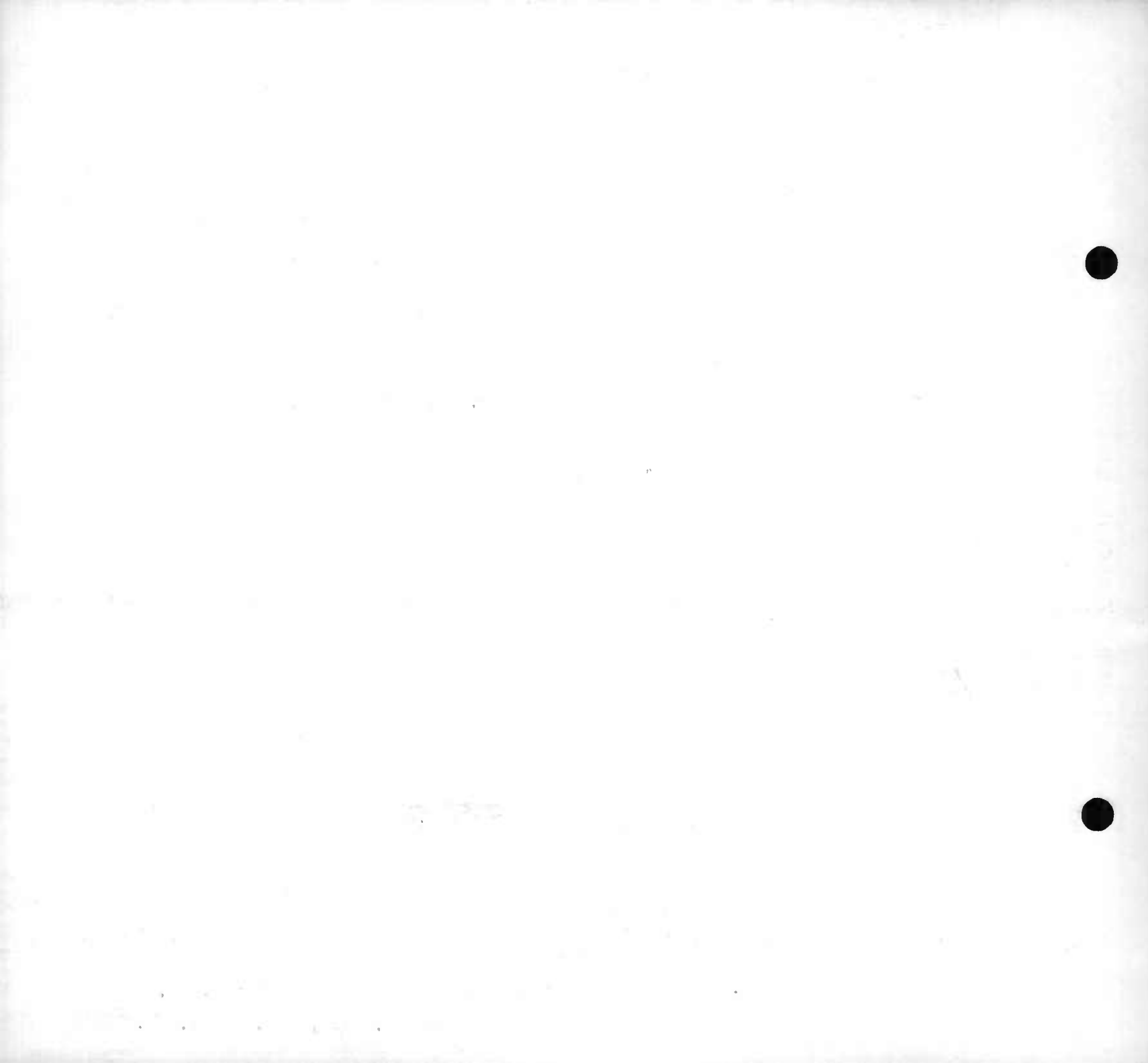
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-252		70 1523		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1523	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Adriana Ascenzi</i> (Ascenzi)			
2. DATE AND HOUR OF DEATH <i>2-4-70 11:10 P.M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>37 Mercy Hospital, Inc.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2641</i>			
5. SEX <i>F</i> 6. RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>12-05-31</i> 9. AGE (in years last birthday) <i>38</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Italy</i>				12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>			
13. FATHER'S NAME <i>Bernard Fabrizi</i>				14. MOTHER'S MAIDEN NAME <i>Maria Ruggeri</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Mr. Gerlando Ascenzi</i>				ADDRESS (Same)			
18. <i>174X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Cardio respiratory failure</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic breast carcinoma</i>			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>1 1/2 years</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>01-02-70</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Above mentioned</i>			
20A. AUTOPSY? (Yes or No) <i>NO</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>NO</i>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
21G. White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21H. Jan. 1, 1970 to Feb. 4, 1970			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1, 1970</i> to <i>Feb. 4, 1970</i> that (I) (we) last saw the deceased alive on <i>Feb. 4, 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Randhir Prasad Sinha</i>				23B. DATE SIGNED <i>2.4.70</i>			
23C. PHYSICIAN'S NAME (Type) <i>RANDHIR PRASAD SINHA M.D.</i>				23D. ADDRESS <i>Mercy Hospital - Balto. Md 21202</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>2/9/70.</i>			
24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 9 1970</i>				25B. NAME OF REGISTRAR <i>Reuben E. Bailey, M.D.</i>			
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md.</i>				ADDRESS <i>21214</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-624		70 1524		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1524	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) BRUSCOLINI; DANTE			
2. DATE AND HOUR OF DEATH FEBRUARY 5, 1970 6:35 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 Union Memorial Hospital			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2633		5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8. DATE OF BIRTH 02-25-05		9. AGE (In years last birthday) 64	
E. STREET AND NUMBER 3305 KENYON AVENUE		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mutual CASHIER		10B. KIND OF BUSINESS OR INDUSTRY Race Tracks		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NILO BRUSCOLINI		14. MOTHER'S MAIDEN NAME CORINA (NOT KNOWN)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 216-03-5242		17. INFORMANT Mrs. Sarah Bruscolini		ADDRESS (Same)		18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Acute Myocardial Infarction (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 3 1970 to FEBRUARY 5 1970 that (I) (we) last saw the deceased alive on FEBRUARY 5 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Mig Karacuschansky M.D. DEGREE	
23B. DATE SIGNED FEBRUARY 5, 1970		23C. PHYSICIAN'S NAME (Type) Miguel KARACUSCHANSKY M.D. DEGREE		23D. ADDRESS UNION MEMORIAL Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 2/9/70.		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		VS 150-REV. 1/1/68	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 1525</u>	
H-160 70 1525				CERTIFICATE OF DEATH	
BIRTH NO. <u>37</u>		1. NAME OF DECEASED (Type or Print) <u>JOSEPH N. HUBER</u>		2. DATE AND HOUR OF DEATH <u>2-5-70</u> <u>12:05 a.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy Hospital, Inc.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>906</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1605 E. 29th St.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-1894</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police (City)</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Nicholas L. Huber</u>		14. MOTHER'S MAIDEN NAME <u>Mary Tillman</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW 1</u>		16. SOCIAL SECURITY NO. <u>214-14-9119</u>		17. INFORMANT <u>Joseph F. Scales</u> ADDRESS <u>5008 Harford Rd 21214</u>	
18. <u>4/10/91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Heart myocardial infarction</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>As a result of</u> (B) <u>ASCVD</u> (C) <u>years</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>1/30</u> 19 <u>70</u> to <u>2/5</u> 19 <u>70</u> that (we) last saw the deceased alive on <u>2/5</u> 19 <u>70</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>Barbedo M.D.</u>		23B. DATE SIGNED <u>2/5/70</u>		23C. PHYSICIAN'S NAME (Type) <u>BARBEDO M.D.</u>	
23D. ADDRESS <u>MERCY HOSP</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>2-7-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u> ADDRESS <u>Balto. Md.</u>	

9252

BARREDO A B WEEK 2000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
7-500		70 1526		70 1526	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
RAINEY CHARLES C			FEBRUARY 4, 1970 11.30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL Hospital			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 1655 COLDSPRING LANE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-24-09	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Iron Worker		10B. KIND OF BUSINESS OR INDUSTRY Shipyards	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES RAINEY			14. MOTHER'S MAIDEN NAME ANNA ADAMS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes NW 2		16. SOCIAL SECURITY NO. 235-10-3819	17. INFORMANT Mrs. Elsie K. Rainey		ADDRESS (Same)
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive heart failure</i> (B) <i>pulmonary edema and emphysema</i> (C) <i>Generalized lymphadenopathy</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Dr. Cho</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 27 1970 to FEBRUARY 4 1970 that (I) (we) last saw the deceased alive on FEBRUARY 4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Miguel Karacuschansky</i> M.D.			23B. DATE SIGNED FEBRUARY 4, 1970		23C. PHYSICIAN'S NAME (Type) MIGUEL KARACUSCHANSKY M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 2/9/70.		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery
24D. LOCATION Baltimore, Md.			25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR Leonard J. Buck, Inc. Balto. Md. 21214		

Exposition internationale

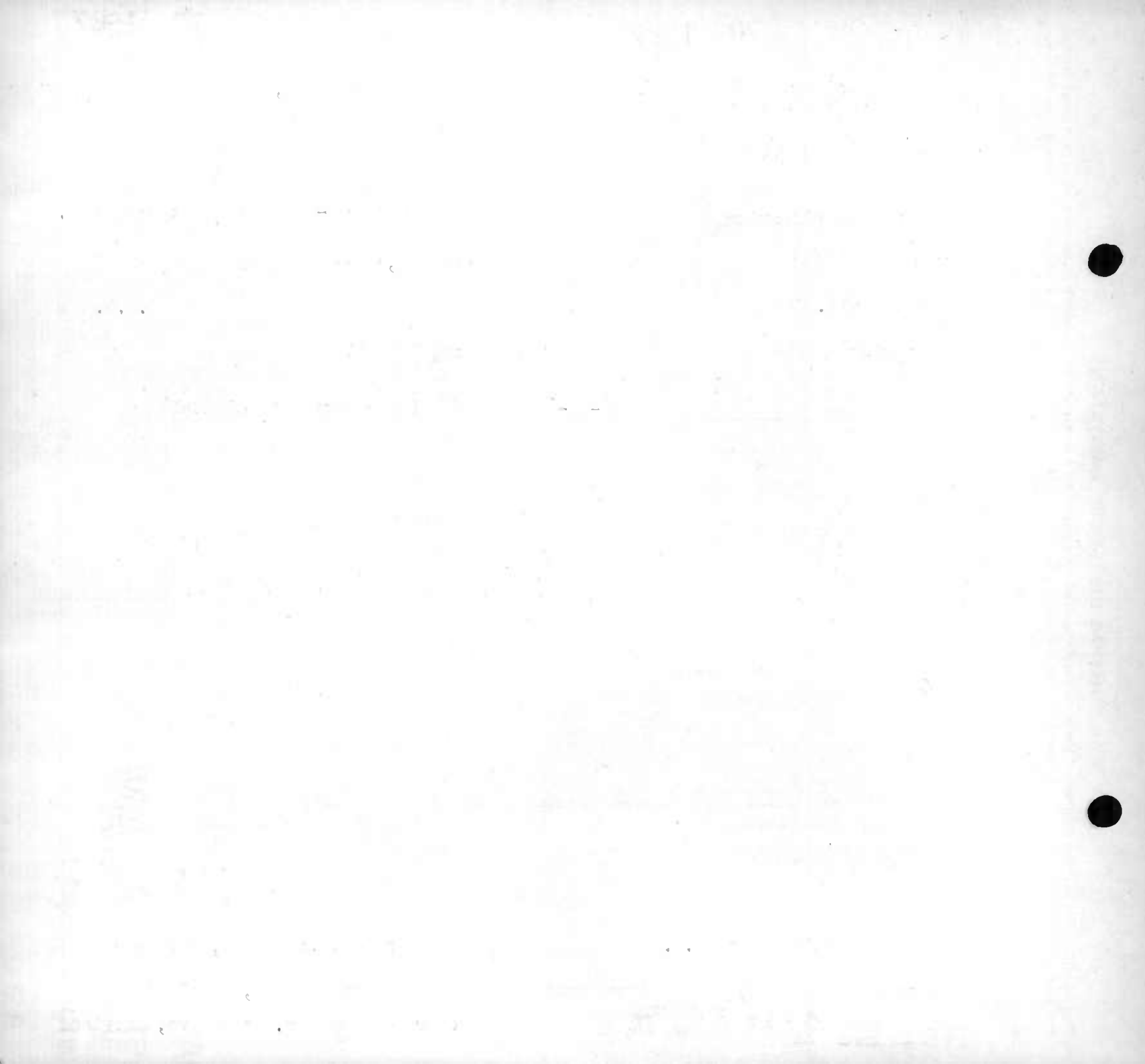
Exposition internationale
Exposition internationale

Exposition internationale

Exposition internationale

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

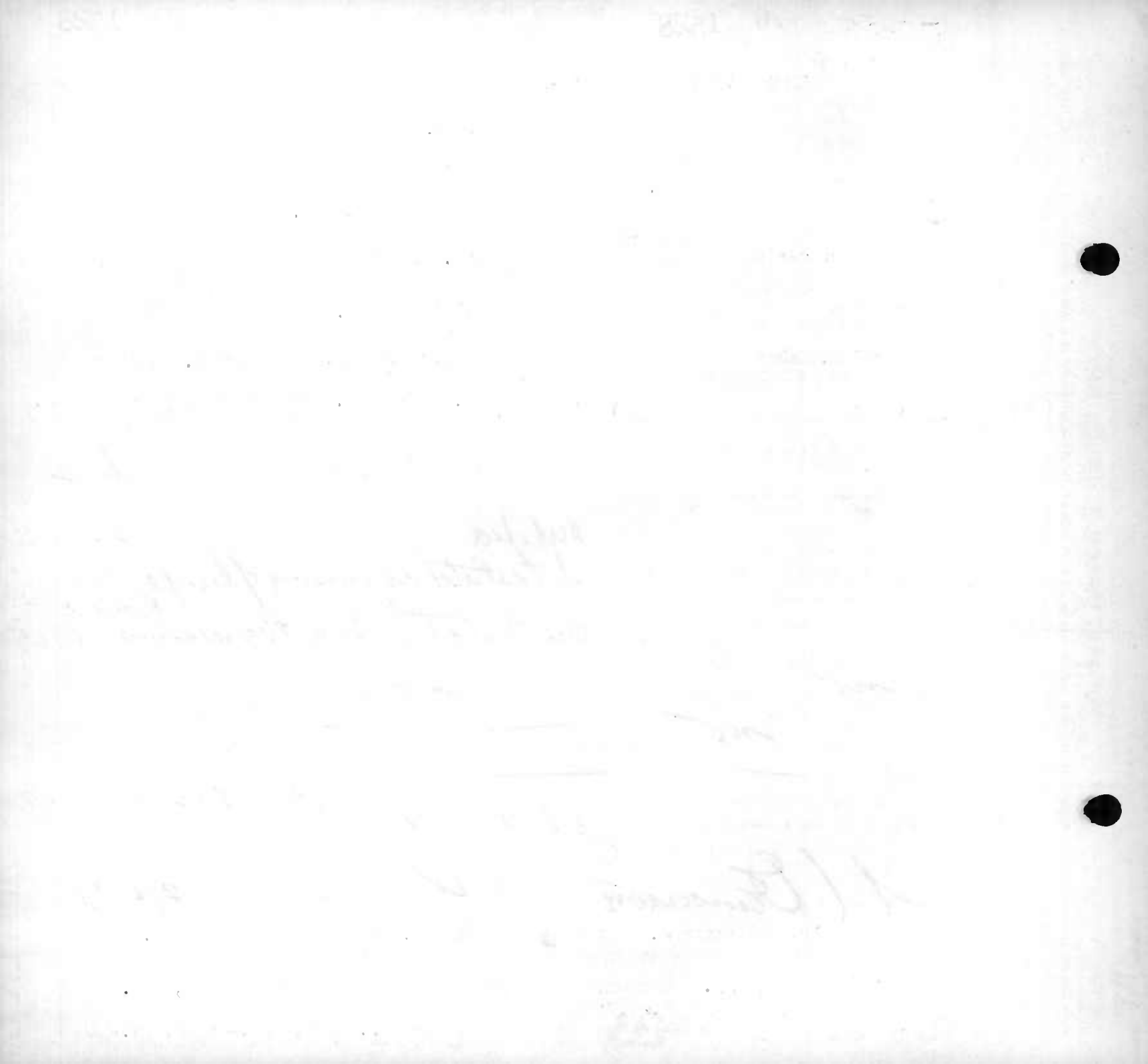
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-656 70 1528		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1528	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EMMA VIRGINIA GREENER		February 6, 1970 2:00 a M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
1601 Sherwood Ave.		Maryland		2758	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
female		caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
housewife				Jan. 4, 1910	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Samuel E. Baker		Margaret J. Shreck		60	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
No		213-03-2597		Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Mr. William R. Greener, 1601 Sherwood Ave.		USA	
ANTECEDENT CAUSES		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		hrs.	
		(B) DUE TO, OR AS A CONSEQUENCE OF:		2 months	
		(C) Metastatic carcinoma of lungs		8 months	
		Metastatic Breast Carcinoma		1965	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		no		no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
no					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1965 to Feb 5 1970, that (I) (we) last saw the deceased alive on 2/2 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
		Dr. Salvatore J. DeMarco		2/6/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR	
Dr. Salvatore J. DeMarco		222 St. Paul St, Baltimore, Md.		Leonard J. Buck, Inc.-Balto, Md.- 14	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2/9/70		Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county)		24E. STATE		24F. ADDRESS	
Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
FEB 9 1970		Robert E. Baker		Leonard J. Buck, Inc.-Balto, Md.- 14	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> H-164 70 1529 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 1529	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) RUTH E. HEBERLEIN		2. DATE AND HOUR OF DEATH February 6, 1970 12:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2904 Rosalie Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2757 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2904 Rosalie Ave. - 34			
5. SEX female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1905	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Schulz		14. MOTHER'S MAIDEN NAME Ella Deal			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr Carl M Herberlein	
				ADDRESS Same	
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Carcinoma of breast & severe metastases to bones & skin (B) DUE TO, OR AS A CONSEQUENCE OF Myocardial failure (secondary) (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 42 to Feb 6 1970 that (I) (was) lost saw the deceased alive on Feb 5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.					
23A. SIGNATURE Dr. Harold V. Harbold				23B. DATE SIGNED Feb. 6, 1970	
23C. PHYSICIAN'S NAME (Type) Dr. Harold V. Harbold				23D. ADDRESS 4706 Harford Road, Baltimore, Md. - 14	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/9/70		24C. NAME OF CEMETERY or CREMATORY Parkwood	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Buck, Inc. - Balto, Md. - 14	

1

70 1530

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1530

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BENJAMIN W. MIKLES Sr.

2. DATE
OF
DEATHKnown ☒ Estimated ☐Month Day Year
February 5, 1970

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital (DOA)

3. DATE
PRONOUNCED DEADMonth Day Year
February 5, 1970

Hour

2:06 A.M.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2706

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

6/2/1898

10. AGE (In years
lost birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2801 Christopher Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Bart Mikles

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Marine Engineer Ret.

14B. KIND OF BUSINESS OR INDUSTRY

Shipping

15. MOTHER'S MAIDEN NAME

Elizabeth Zeller

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL

SECURITY NO.
218-07-6536

18. INFORMANT

Mrs. Wanda Mikles

ADDRESS

same

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

February 5, 1970

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/7/70

24C. NAME OF CEMETERY OR CREMATORY

Moreland Mem. Park

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 9 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md.

ADDRESS

ACADEMIC FUND

RECEIVED

1971

10

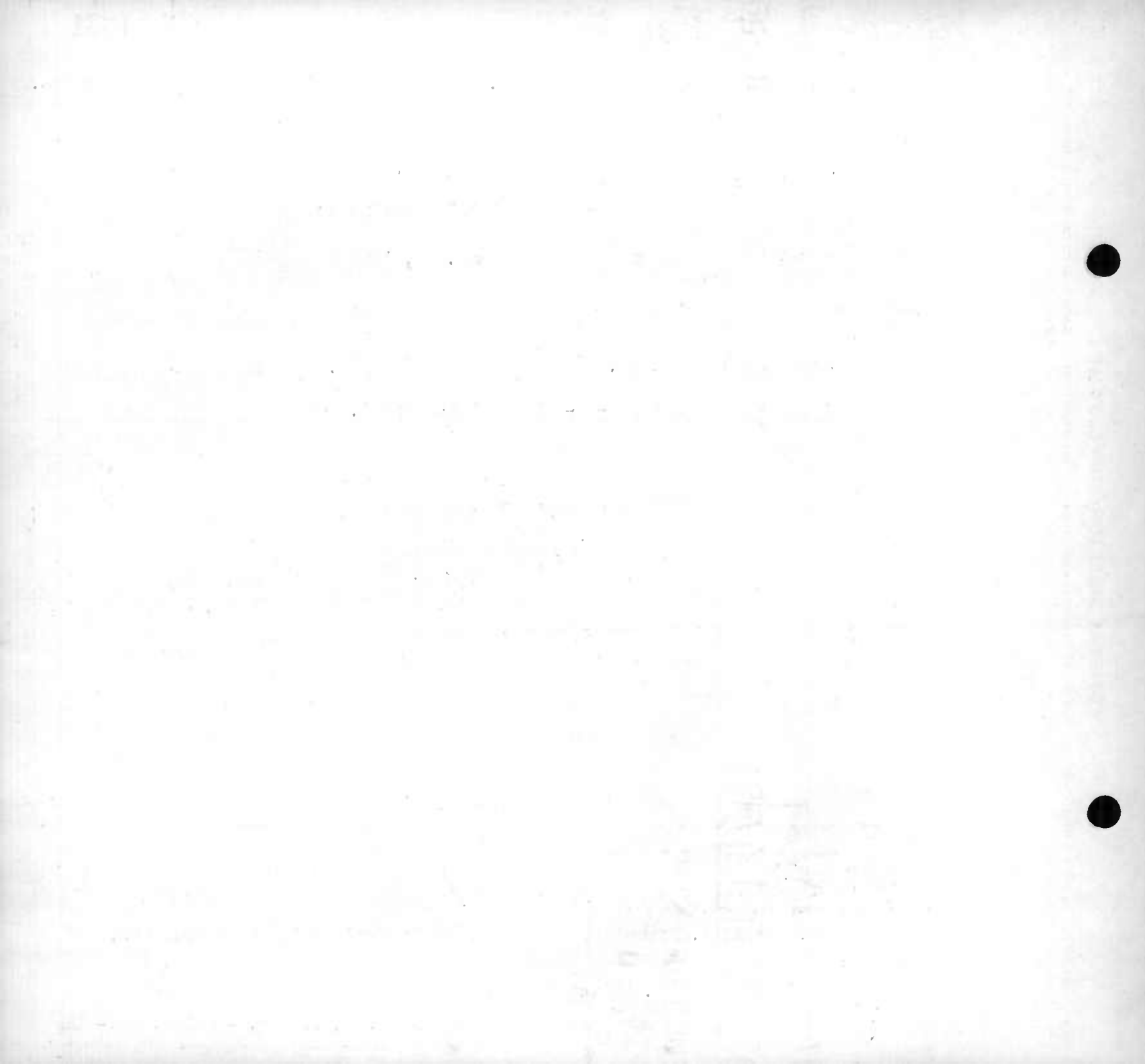
10

10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

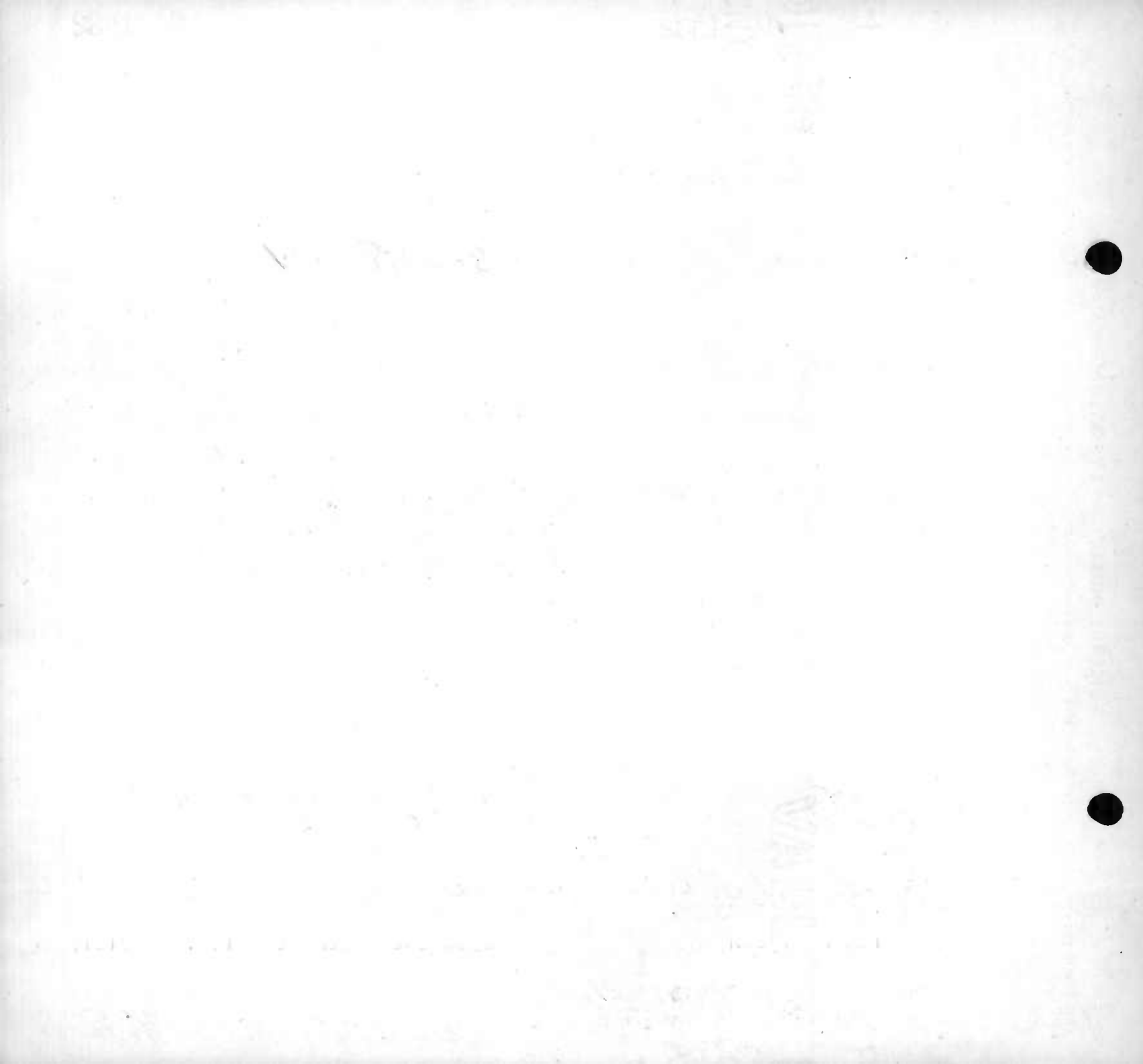
S-530 70 1531		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1531	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GEORGE ANDREW SMITH JR.		Feb. 6, 1970 6:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 2735	
Harford Gardens Nursing Home		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
90		E. STREET AND NUMBER 3011 Rosalie Avenue			
5. SEX male	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 16, 1885	9. AGE (in years last birthday) 84	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Andrew Smith Sr.		14. MOTHER'S MAIDEN NAME Mary E. Luthold	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-16-4455 D1		17. INFORMANT Miss Ida M. Fontz	
18. 471X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Hypostatic pneumonia Influenza (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C-V disease (C) Pulmonary fibrosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 10 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1965 to Feb 6 1970, that (I) (we) last saw the deceased alive on Feb 5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Dr. Harold V. Harbold		23B. DATE SIGNED Feb. 6, 1970		23C. PHYSICIAN'S NAME (Type) Dr. Harold V. Harbold	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/9/70		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. - Balto, Md. - 14	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Balto, Md. - 14		25D. ADDRESS		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

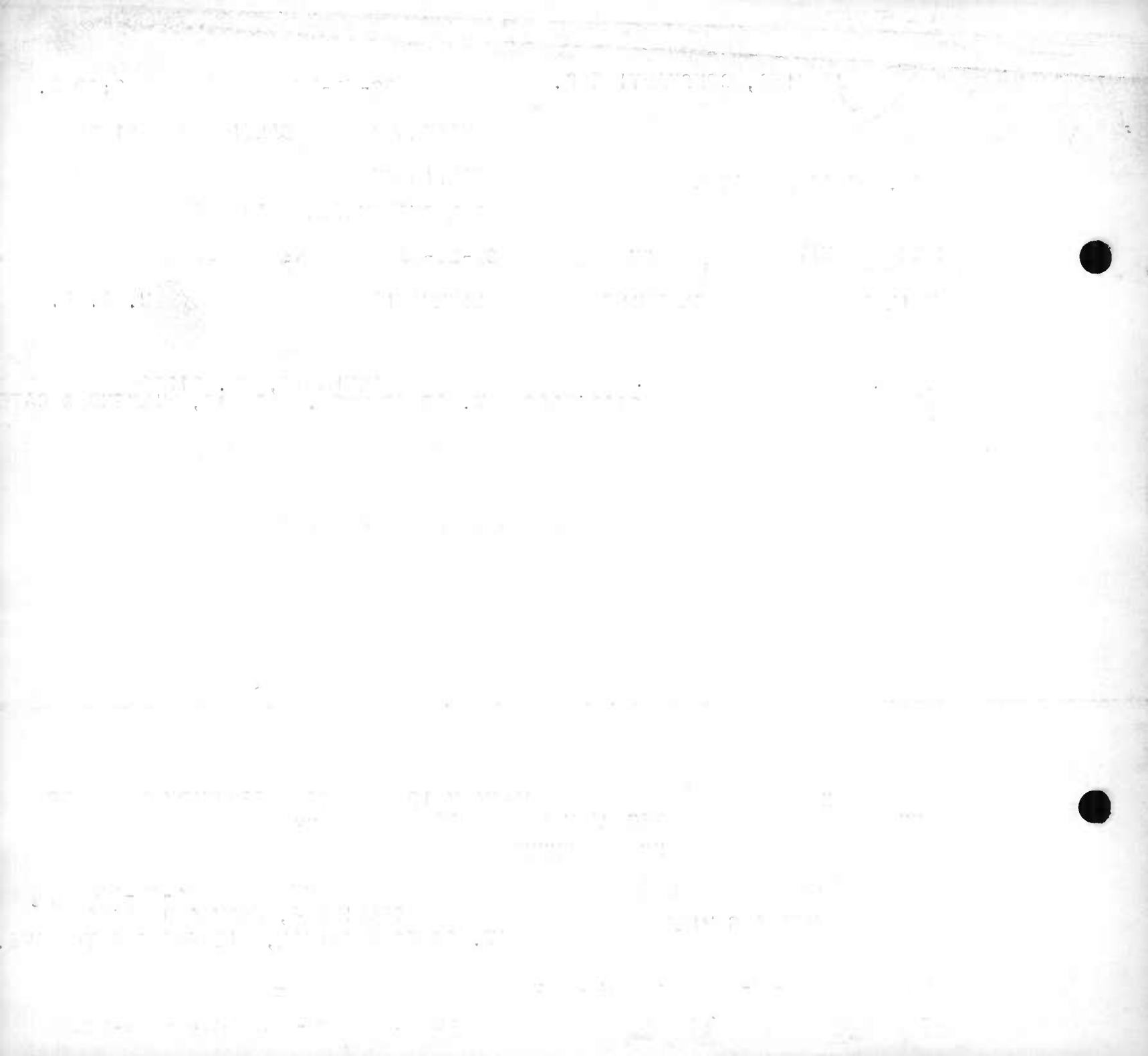
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1532	
BIRTH NO. M-620 70 1532		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Benjamin Myers			2. DATE AND HOUR OF DEATH 2-6-1970 2:30 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nurs. Home (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 808 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1805 W. Chase Street		
5. SEX male	6. RACE non white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-99	9. AGE (In years lost birthday) 71	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police			10B. KIND OF BUSINESS OR INDUSTRY Police		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Phillip Myers			14. MOTHER'S MAIDEN NAME MARY TASCO		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 218-14-9190		
17. INFORMANT Chart # 911			ADDRESS 607 Penna. Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Apoplexy Unrealized Atherosclerosis Operated Prostatectomy 4/14/69 Anemia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4 JUNE 19 69 to 6 Feb 19 70, that (I) (we) last saw the deceased alive on 2 Feb 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard Tyson MD				23B. DATE SIGNED 2-6-70	
23C. PHYSICIAN'S NAME (Type) Richard Tyson MD				23D. ADDRESS 2320 Eutaw Street Balto. Md 21217	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-10-70		24C. NAME of CEMETERY or CREMATORY MILLENARY CEM.	
24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL CO.		25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970			
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]			
25D. ADDRESS 1428 E. Preston St.		25E. ADDRESS [Signature]			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
B-626 70 1534		70 1534		70 1534	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Frank Anton Brugger, III		Feb. 5, 1970		14 15 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway		A. STATE Va.		B. COUNTY V-43	
		C. CITY OR TOWN Arlington		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 124 N. Galveston St.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 6, 1945	9. AGE (in years last birthday) 24	10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Frank A. Brugger Jr.		14. MOTHER'S MAIDEN NAME Helen Shaughnessy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 224-58-1849		17. INFORMANT Records- US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF:				1 WEEK	
(B) METASTATIC CHORIO CARCINOMA DUE TO, OR AS A CONSEQUENCE OF: OF TESTIS				2 YRS	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1970 to Feb. 5, 1970 that (I) (we) last saw the deceased alive on Feb. 5, 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John D. Gelin M.D.				23B. DATE SIGNED 2-5-70	
23C. PHYSICIAN'S NAME (Type) JOHN D. GELIN M.D.				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-70		24C. NAME OF CEMETERY or CREMATORY Calvary, Fairfax, Va.	
24D. LOCATION FAIRFAX VA.		24E. DATE REC'D BY HEALTH DEPT. FEB 9 1970		24F. NAME OF REGISTRAR Robert E. Taylor, Md.	
24G. NAME OF REGISTRAR		24H. FUNERAL DIRECTOR		24I. ADDRESS Hollywood - 5/16/70	

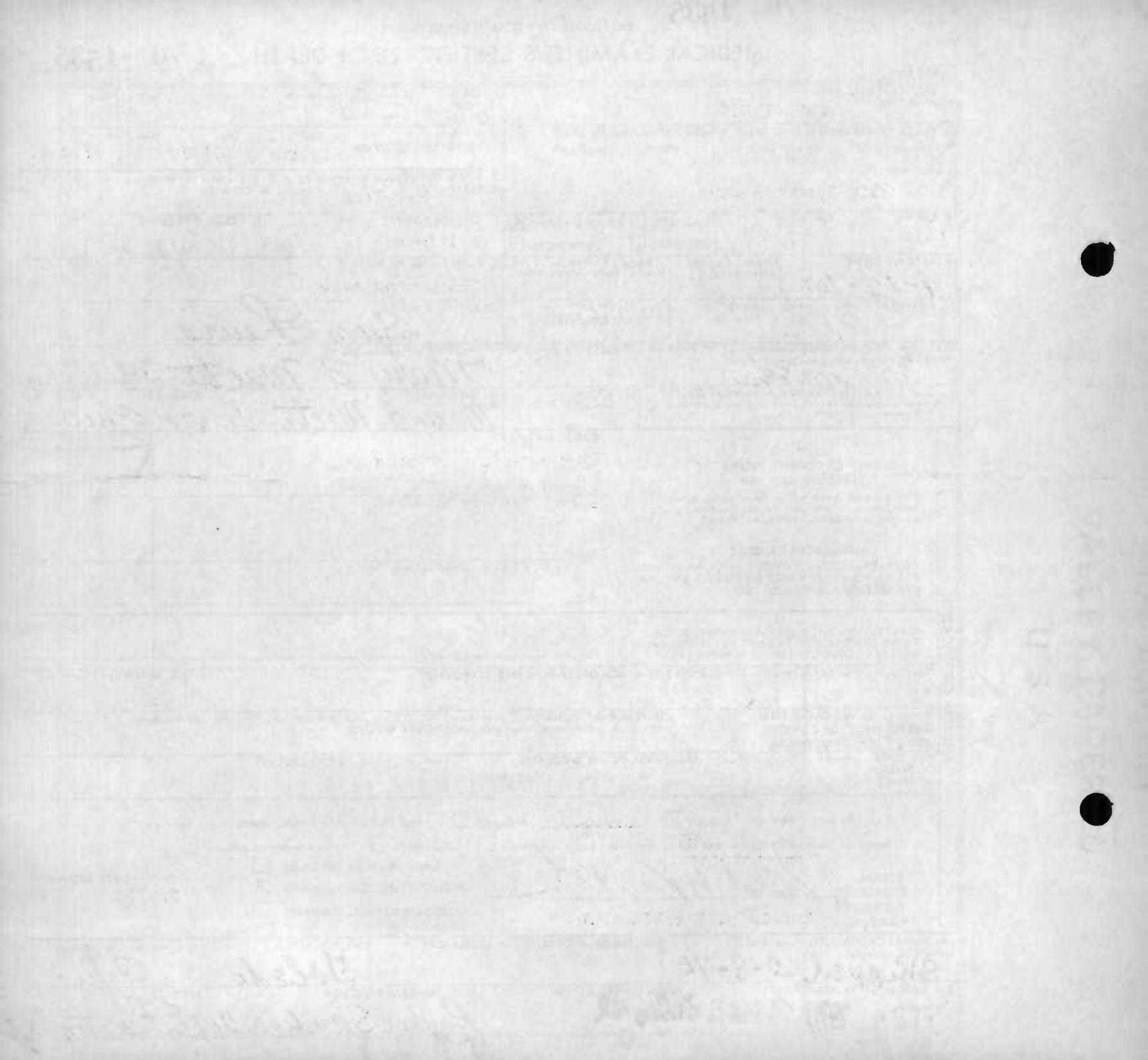


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1535

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRED LEWIS		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2818 Bormon Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour February 3, 1970 2:10 P.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-13	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1-12-29		10. AGE (In years lost birthday) 41		E. STREET AND NUMBER 2818 Borman Avenue	
11. BIRTHPLACE (State or foreign country) Ala		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Sam Lewis	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary B. Macie Toledo Ohio	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mary B. Macie Lewis Ohio	
19. 19901 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Metastatic Carcinoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/4/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Shipped		24B. DATE 2-8-70		24C. NAME OF CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Rayner Sanders	
				24D. LOCATION (City, town, or county) (State) Toledo Ohio	
				ADDRESS 217 E. Preston St	



1 *M-620* 70 1536 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 70 1536
 BIRTH NO. REG. NO.

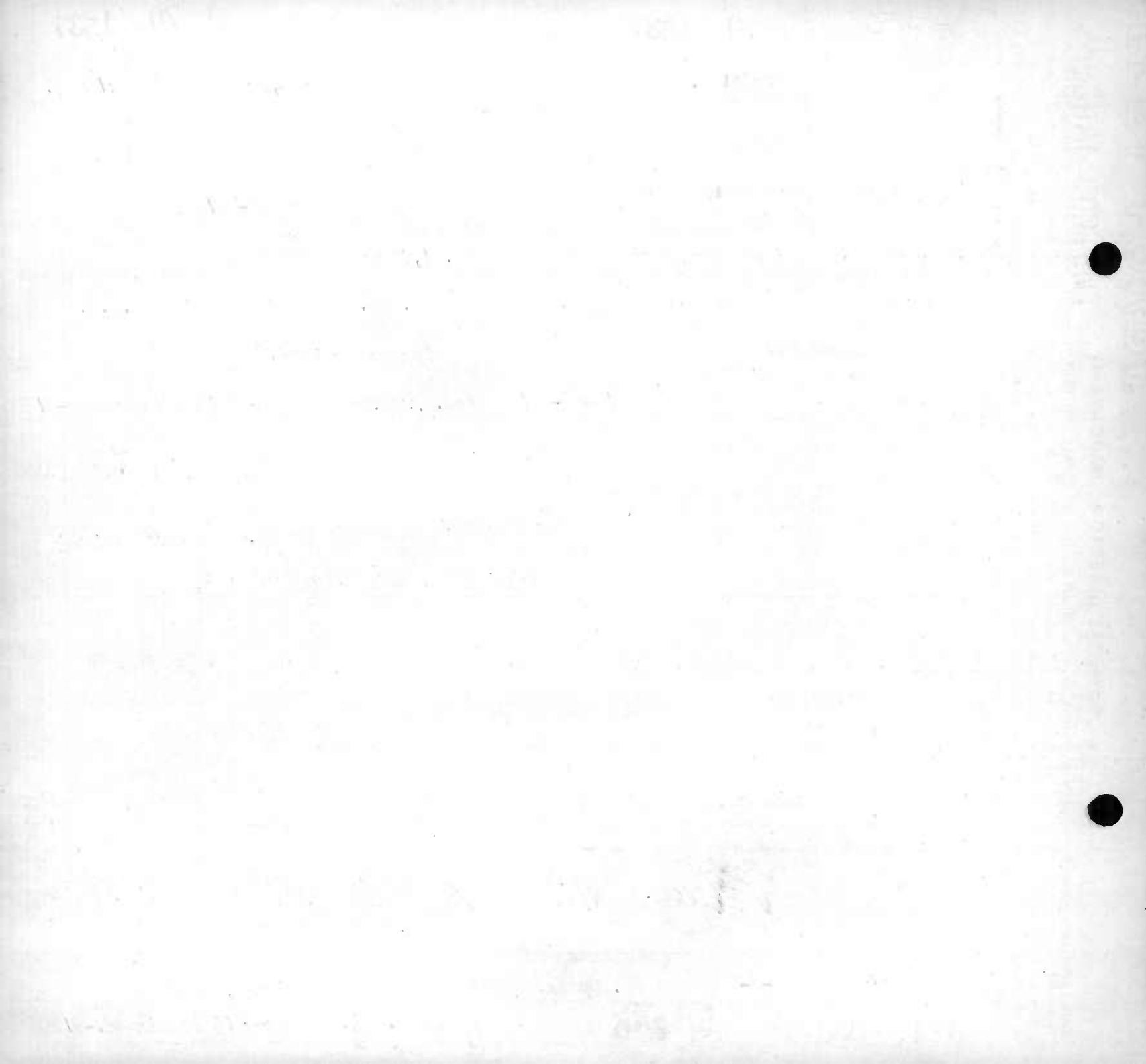
1. NAME OF DECEASED (Type or Print) LUNA MYERS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> January 17, 1970		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (DOA) South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour January 17, 1970 7:25 P.		M.	
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 17, 1924		10. AGE (In years last birthday) 45		11. BIRTHPLACE (State or foreign country) Pittsylvania Co., Va.	
12. CITIZEN OF USA		13. FATHER'S NAME Carrington Roach		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Lucy Brooks Roach		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) -		17. SOCIAL SECURITY NO.	
18. INFORMANT Jimmy C. Myers		ADDRESS 83 Paterson Ave. Paterson, N. J.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. E-81571 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
(A) IMMEDIATE CAUSE Multiple traumatic injuries DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2800 Waterview Ave. W. of Annapolis Rd.	
22D. TIME OF INJURY (APPROX.) 1-17-70 7:00 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Passenger in auto-fixed object collision	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 18, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-70		24C. NAME OF CEMETERY or CREMATORY Grentna Burial Park	
24D. LOCATION (City, town, or county) Grentna, Virginia		24E. NAME OF REGISTRAR Colbert Funeral Home		24F. ADDRESS Grentna, Va.	

VS 151-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

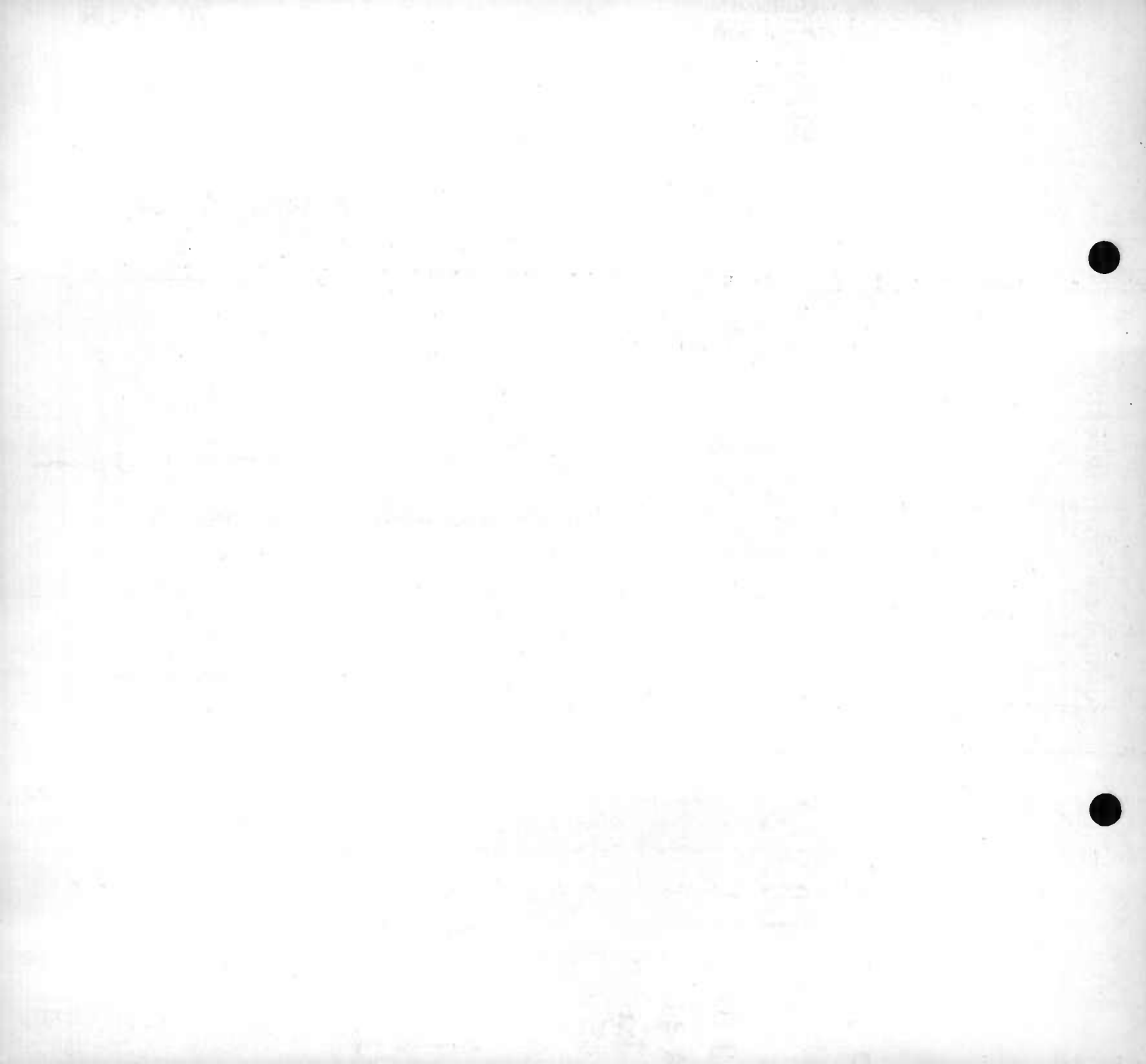
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1537	
A-450		70 1537		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Katherine M. Allen		February 3, 1970		8:15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
		Maryland		2744	
90 Gould Convalescent Home		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		6013 Alta Avenue- 21206			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 1, 1890	79	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Cashier		City of Baltimore		Balto. Md.	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Joseph Ott		Margaret Limmer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-05-7516		Mrs. Margaret Ernst - 6013 Alta Avenue-21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cardiac Decompensation due to severe Arteriosclerotic Cardiovascular disease	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/27</u> 19 <u>70</u> to <u>2/3</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>2/2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
[Signature]		2/5/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2-6-70		Mt. Carmel Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 9 1970		[Signature]		John G. Miller Inc-6415 Belair Rd.-21206	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 1538
K-52070 1538 KNEIS		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Hilda KNEIS		2-4-70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 43 S.B.G.W.			A. STATE Md. B. COUNTY 2404		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1504 Boyle ST		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-22	9. AGE (In years lost birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE				Md.	
13. FATHER'S NAME John G. KNEIS			14. MOTHER'S MAIDEN NAME Alice Williamson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Family - Same	
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			acute status asthmaticus 3 years		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			chronic allergic asthma		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C).....		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 28 1967 to 7/29 1970, that (I) (we) lost saw the deceased alive on 11/29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Ronald V. Kuo M.D.				23B. DATE SIGNED 2/5/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				707 E. Fort Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
B		2-6-70		Glen Haven BALTIMORE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 9 1970		Robert E. Taylor		1504 Boyle ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

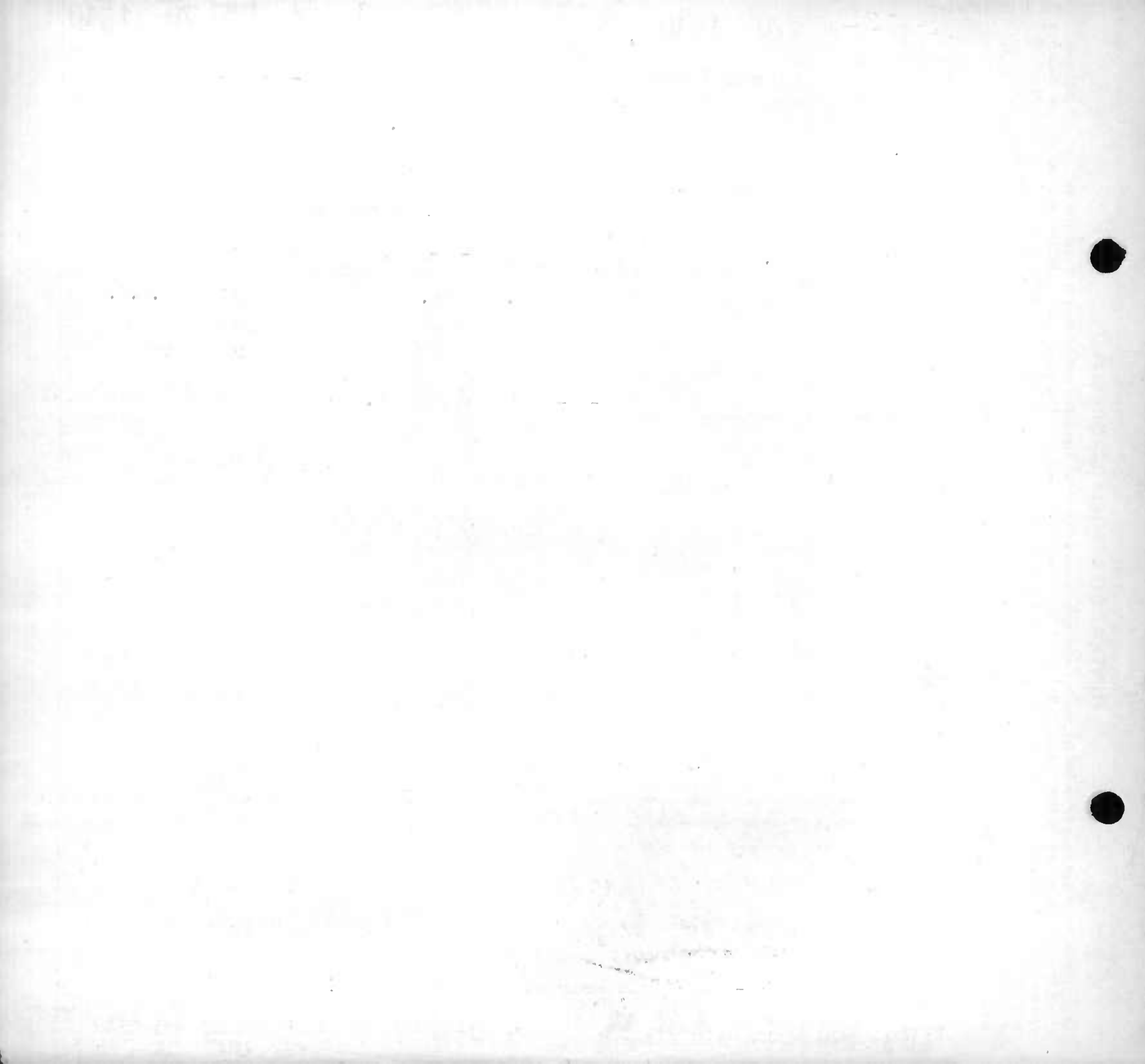
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 1539	
<p>C-160 70 1539</p> <p>BIRTH NO. <i>Wicomico Co. Md.</i></p> <p>1. NAME OF DECEASED (Type or Print) DANA RAE COOPER</p>		<p>2. DATE AND HOUR OF DEATH 11*5*8) 2-4-70 1:40P M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION 3 THE JOHNS HOPKINS HOSPITAL</p> <p>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY WICOMICO 72-00</p> <p>C. CITY OR TOWN PITTSVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER BOX 101</p>			
<p>5. SEX FEMALE</p> <p>6. RACE WHITE</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 12-24-64</p> <p>9. AGE (In years last birthday) 5</p> <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>-----</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p>-----</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p> <p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Medford FRANKLIN COOPER</p>		<p>14. MOTHER'S MAIDEN NAME DARLENE PARSONS</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>no</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT (Father) Mr. Frank M. Cooper ADDRESS Box 101, Pittsville, Md.</p>	
<p>18. 204.01 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
<p>19A. DATE OF OPERATION 2</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) YES</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 2/3 19 70 to 2/4 19 70 that (I) (we) last saw the deceased alive on 2/4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Joseph T. Coyle M.D.</p>		<p>23B. DATE SIGNED 2/4/70</p>		<p>23C. PHYSICIAN'S NAME (Type) JOSEPH COYLE M.D.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 2/7/70</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery</p>	
<p>24D. LOCATION (City, town, or county) Pittsville, Maryland</p>		<p>24E. STATE (State) Maryland</p>		<p>25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970</p>	
<p>25B. NAME OF REGISTRAR Robert E. Taylor</p>		<p>25C. FUNERAL DIRECTOR Holloway & Company</p>		<p>ADDRESS Salisbury, Maryland</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.		70 1540	
BIRTH NO. <u>I-522</u>				70 1540		70 1540	
1. NAME OF DECEASED (Type or Print) <u>James Inches</u>				2. DATE AND HOUR OF DEATH <u>2-2-1970</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.co.</u> <u>5300</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>313 Langley Road 21221</u>			
5. SEX <u>Male</u>	6. RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-1903</u>		9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Holy Redeemer Cem.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Inches</u>				14. MOTHER'S MAIDEN NAME <u>Mary Howard</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>168-03-8585</u>		17. INFORMANT ADDRESS <u>Dorothy M. Inches 313 Langley Road 21221</u>			
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH <u>ACUTE MI</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIOGENIC SHOCK</u> (B) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8:30 A.M. Feb. 2 1970</u> to <u>10:10 A.M. Feb. 2 1970</u> , that (I) (we) last saw the deceased alive on <u>8:30 A.M. Feb. 2 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Notulearm... M.D.</u>				23B. DATE SIGNED <u>2-4-70</u>		23C. PHYSICIAN'S NAME (Type) <u>N. M. CARROLLA, M.D.</u>	
23D. ADDRESS <u>c/o UNION MEM. HOSP.</u>				23E. DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-5-1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore City Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>		25B. NAME OF REGISTRAR <u>Wm E. Kelly</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		25D. ADDRESS <u>7401 Belair Road 21236</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1541	
B-263 70 1541		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Joseph S. Beckhardt		2. DATE AND HOUR OF DEATH 2-7-70 7:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2101			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland 46		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 748 Ramsey Street					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-17-99	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Koppers Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Simon Beckhardt		14. MOTHER'S MAIDEN NAME Helen M. Belt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-09-8621A		17. INFORMANT Miss Helen Palmer	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 209X I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure (B) DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA. (C) AGNOSTIC MYELOID METAPLASIA.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Limited Adrenocortical Reserve due to long-term corticosteroids (T)					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? (medicine)	
22. I certify that (I) (this hospital) attended the deceased from 2/6/70 19 70 to 2/7/70 19 70 , that (I) (we) last saw the deceased alive on 2/7/70 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Subash C. Ahuja, M.D.		23B. DATE SIGNED 2/7/70			
23C. PHYSICIAN'S NAME (Type) SUBASH C. AHUJA M.D.		23D. ADDRESS Lutheran Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/10/70		24C. NAME OF CEMETERY or CREMATORY Landon Park Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR John J. Conner		25C. FUNERAL DIRECTOR John J. Conner	

FUNERAL DIRECTOR: IMPORTANT

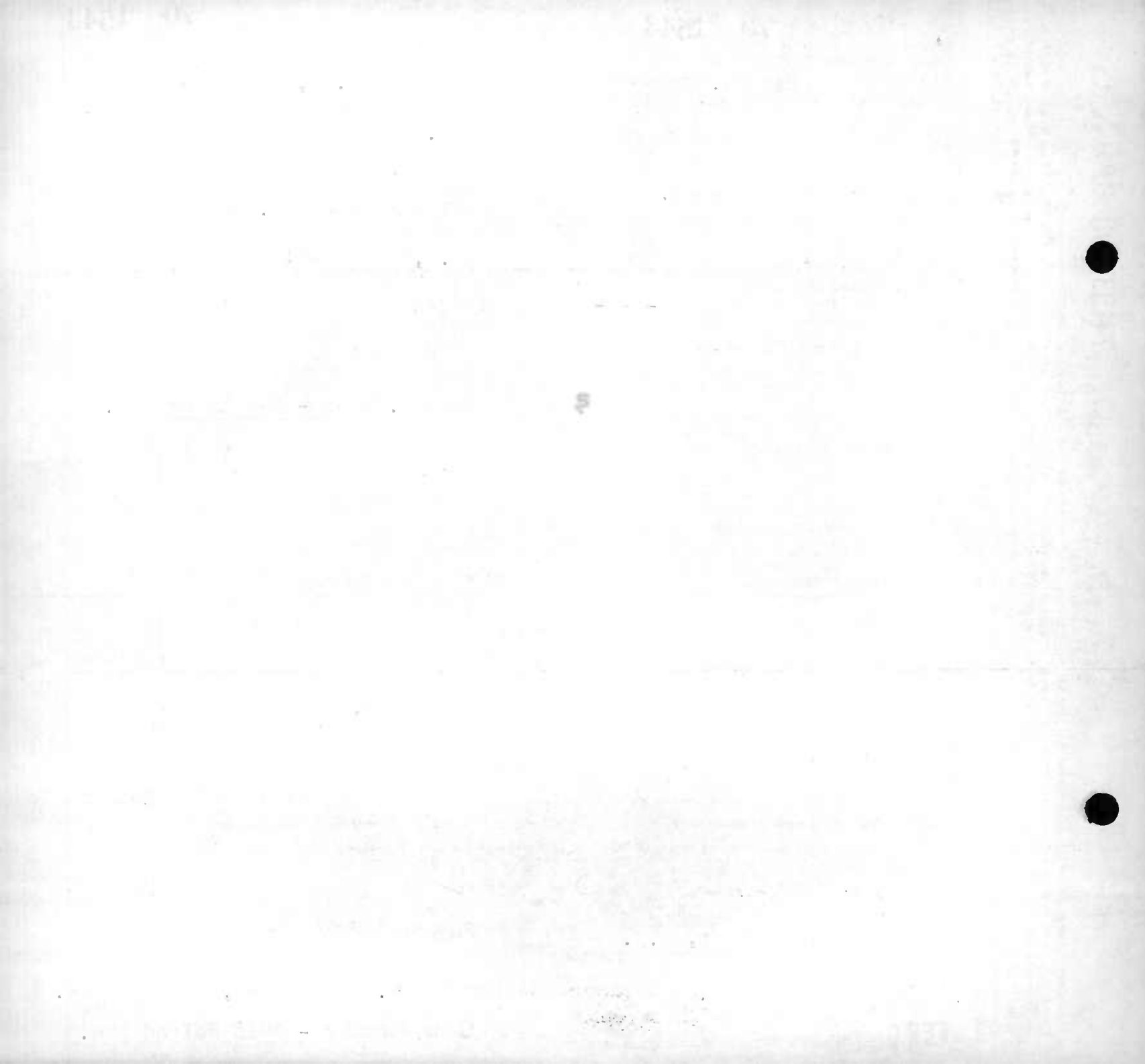
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1542	
BIRTH NO. Y-524		70 1542 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ALICE MAE YINGLING		2. DATE AND HOUR OF DEATH February 6, 1970 3:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, 21224, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2608	
5. SEX Female		6. RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1916	
9. AGE (In years last birthday) 53		10. AGE (In years last birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10B. KIND OF BUSINESS OR INDUSTRY At Home.	
11. BIRTHPLACE (State or foreign country) Monessen, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Williams		14. MOTHER'S MAIDEN NAME Ann	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-6283	
17. INFORMANT Albert E. Yingling		ADDRESS Same.	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anterolentic C.V. dis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 10 19 64 to Jan. 6 19 70 , that (I) (we) last saw the deceased alive on Jan. 6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Benjamin Highstein M.D.		23B. DATE SIGNED 2/7/70	
23C. PHYSICIAN'S NAME (Type) BENJAMIN HIGHSTEIN		23D. ADDRESS 121 S. Highland Ave., Balto., 21224, Md.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 2-9-70.	
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Charles J. Giler		ADDRESS 901 S. Conkling St. Baltimore, 21224, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

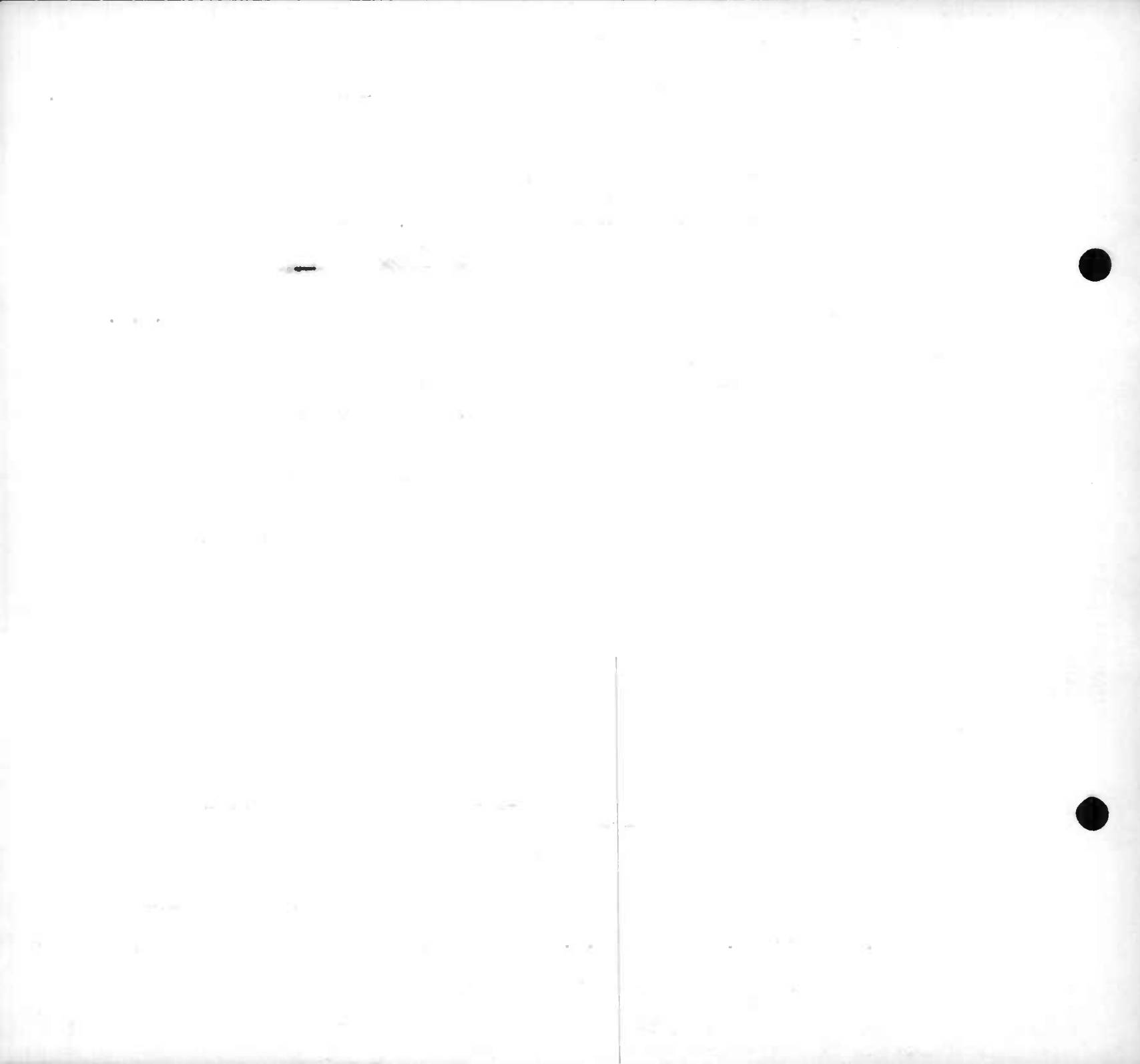
S-360 70 1543		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 1543	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary C. Starr		Feb. 6, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md.		1203	
00 401 Ilchester St.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 401 Ilchester St.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 9, 1898	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		-		Ireland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Patrick Kearney		Unknown		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		3		James T. Starr - 34 Elmont Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 years	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Diabetes mellitus			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4-24 19 64 to 2-6 19 70, that (I) (we) last saw the deceased alive on 2-2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Reuben Hoffman, M.D.		2-7-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Reuben Hoffman, M.D.		846 W. 36th St., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2/10/70		Baltimore National Cem.	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 9 1970		Ann Donovan		3818 Roland Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

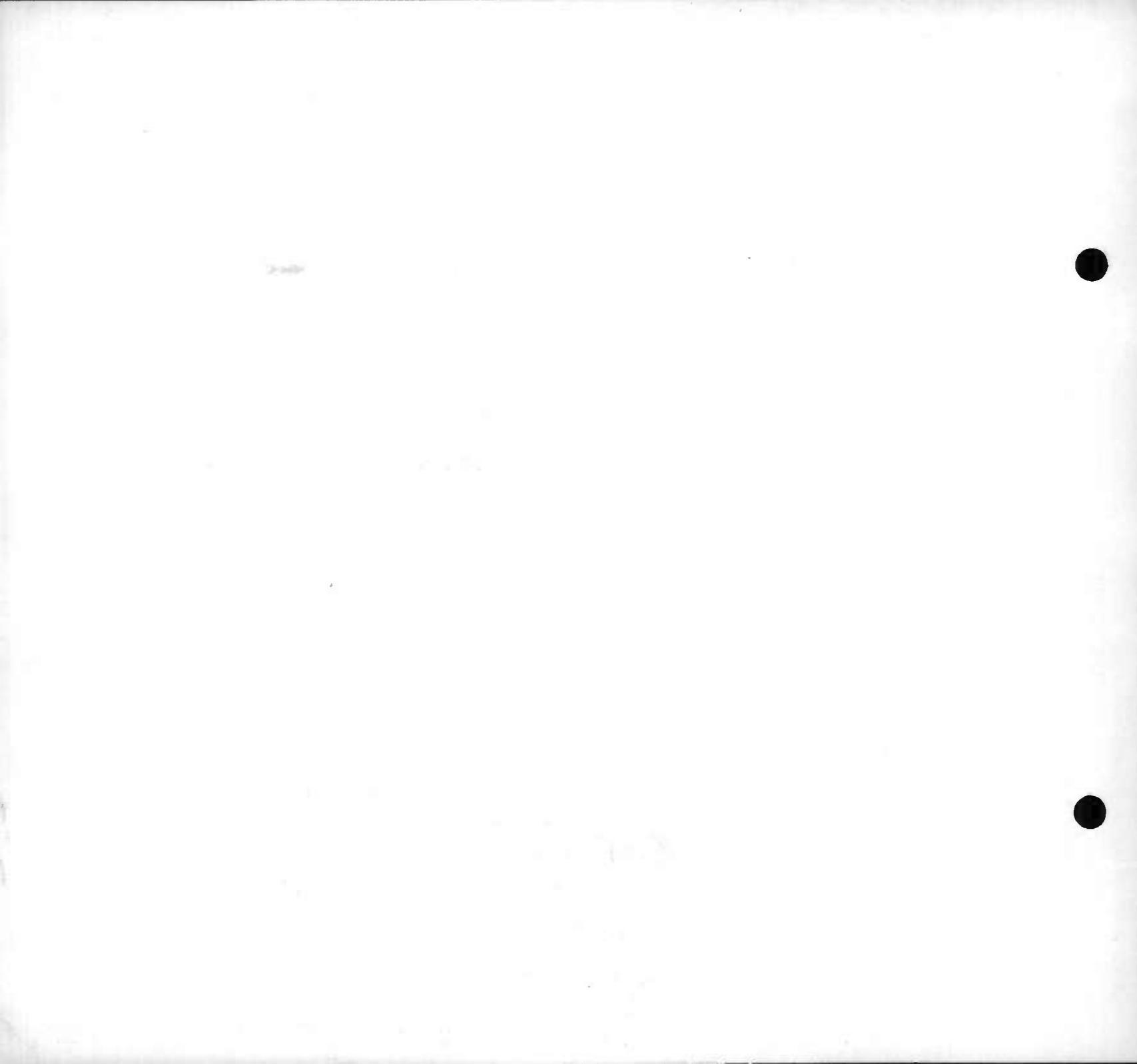
B-412 70 1544				BALTIMORE CITY HEALTH DEPARTMENT		70 1544	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Frances Billoups				2-7-70 1:15 a. m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
39		Provident Hospital Inc. 1514 Division Street Baltimore, Maryland		Maryland		1603	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH				9. AGE (In years last birthday)		10. BIRTHPLACE (State or foreign country)	
8-23-1906				63		North Carolina	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
REUBEN TILLEY				Florence			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NV						Mr. Edward Billoups (Husband) Same	
18. 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Cirrhosis of the Liver			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Chronic Alcoholism & Dehydration			
				DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1-25-70 to 2-7-70 that (I) (we) last saw the deceased alive on 2-7-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. Raymundo R. Corpuz M.D.				2-7-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Raymundo R. Corpuz M.D.				1514 Division Street Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		2/1/70		Mt Auburn		Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
FEB 9 1970		Robert E. Taylor, M.D.		Margaret P. Hayes		638 N. Green St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-325 70 1545		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1545	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>George Watkins</u>		2. DATE AND HOUR OF DEATH <u>2/4/70</u> <u>1 936 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1104 W. Lexington ST. 1802</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>		E. STREET AND NUMBER			
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/3/1907</u>	9. AGE (in years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labron</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Clarence</u>		14. MOTHER'S MAIDEN NAME <u>Georgetta Watkins</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>THELMA WATKINS - Daughter</u> ADDRESS	
18. <u>485X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Broncho-Pneumonia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Broncho-Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Wks.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2-4-70</u> to <u>2-4-70</u> that (I) (we) last saw the deceased alive on <u>2-4-70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Varah Vorasubin, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>2-4-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>VARAH VORASUBIN, M.D.</u>		23D. ADDRESS <u>Bon Secours Hosp. Balto, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/7/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>635 79th Ave</u>	



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BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 1546			
BIRTH NO. S-352											
1. NAME OF DECEASED (Type or Print) JOSEPH STANIEWSKI						2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1402 E. Lombard Street						3. DATE PRONOUNCED DEAD Month Day Year Hour January 31, 1970 2:45 P. M.					
6. SEX Male						7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 301	
9. DATE OF BIRTH 3/11/1900		10. AGE (In years last birthday) 69		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ignatius		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body tender work	
15. MOTHER'S MAIDEN NAME Mary Rokot						16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI					
17. SOCIAL SECURITY NO. 705-12-59279						18. INFORMANT Mrs. Frances Stanley - Nevecon					
19. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cirrhosis					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.						(B) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						(C)					
20A. DATE OF OPERATION 2						20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
21. AUTOPSY? (Yes or No) Yes											
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?											
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)						22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22F. HOW DID INJURY OCCUR?											
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Charles S. Springate, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED February 1, 1970											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 2/14/70		24C. NAME OF CEMETERY or CREMATORY Belling Nat'l Cem				24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970				25B. NAME OF REGISTRAR Robert E. Taylor, R.D.				25C. FUNERAL DIRECTOR Joseph M. Zannone 263 Stoddard St			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 1547</u>	
T-554 <u>70 1547</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>STEPHEN TUMINELLI</u>		2. DATE AND HOUR OF DEATH <u>2-7-70</u> <u>245</u> <u>A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>425 SINAI Hospital BALTO</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY _____	
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed - disabled</u>		8. DATE OF BIRTH <u>7-6-14</u> 9. AGE (In years last birthday) <u>55</u>	
10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>	
13. FATHER'S NAME <u>Archangelo Tuminelli</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Adelaine Catalano</u>	
16. SOCIAL SECURITY NO. <u>217-07-8926</u>		17. INFORMANT <u>Mrs. Louise Tagliaferri Tuminelli</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>410.91-250.9</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetic nephrosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>10 yrs. +</u>	
19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>approximately</u> <u>19 67</u> to <u>2-7</u> <u>19 70</u> that (I) <u>we</u> last saw the deceased alive on <u>JAN 6</u> <u>19 70</u> and that (in my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <u>did</u> (did not) view the body after death. <u>D.O.A. SINAI Hosp.</u>			
23A. SIGNATURE <u>H. Gerard Oster</u>		23B. DATE SIGNED <u>2-7-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. GERARD OSTER</u>		23D. ADDRESS <u>90 SINAI Hospital BALTO MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/10/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Joseph P. Jannino</u>		ADDRESS <u>263 S. Conkling St</u>	



U-256 70 1548 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 1548

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/>	
		F. Bernard Wagner			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY	
00 4119 St. George Ave.		2 2 70 11:10P		Maryland 2710	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN		D. INSIDE CITY LIMITS?
male	caucasian		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH	10. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME
1-31-27	42 40?	MARYLAND	USA		LOUIS R. WAGNER
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
CLERGY		UNEMPLOYED		MARY ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
YES WWII		220-20-0389		JUNCIE 1116 ORLEANS Way CHAS. OHARA KENSINGTON Md	
57181		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No)
2					Partial
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER			
		ASSOCIATE MEDICAL EXAMINER			
		Deputy Chief Medical Examiner		2/3/70	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		2-6-70		LODGE PARK National Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 9 1970		Robert A. D. ...		DeVol FUNERAL HOME Washington D.C.	

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FUNERAL DIRECTOR: IMPORTANT

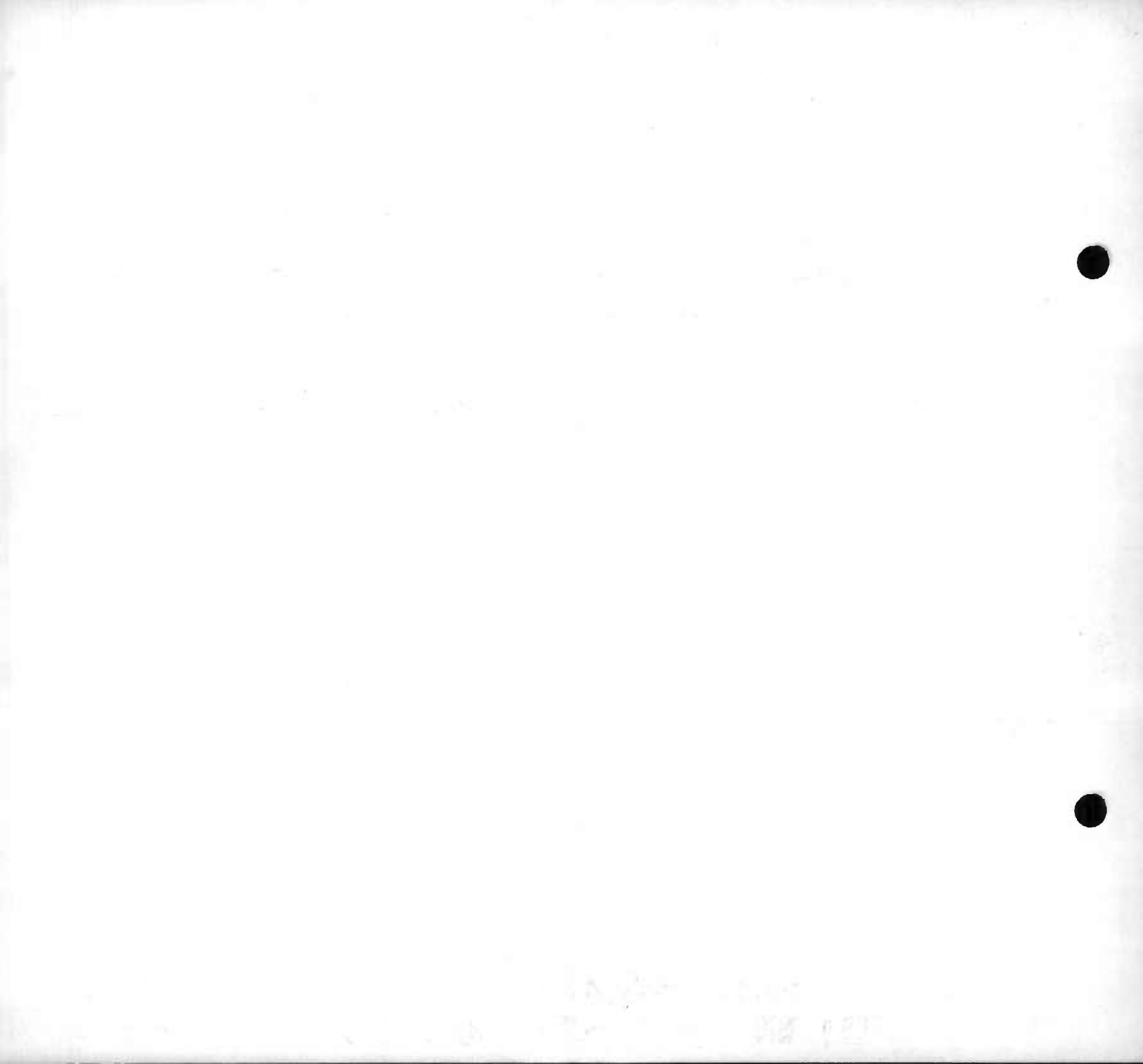
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>553</u>
70 1549		70 1549		
1. NAME OF DECEASED (Type or Print) <u>Wanda ANN Gorski</u>		2. DATE AND HOUR OF DEATH <u>2-4-70</u> <u>12:20 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>carroll co.</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Harbor View Nursing Center</u> <u>1213 Light STREET</u>		E. STREET AND NUMBER <u>Springfield State Hosp.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-94</u>	9. AGE (In years lost birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Rydzewski</u>		
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>212-03-2057</u>		17. INFORMANT <u>Miss Stephanie Gorski</u> ADDRESS <u>2502 FLEET ST.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>412.41</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Handstall</u> <u>A.B.C.U.D.</u> (B) <u>Lt. Hemiplegia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Art. Sclerosis</u> (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>chronic Brain Syndrome</u>				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> 19 <u>70</u> to <u>2-4</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Kenneth Krulwitz MD</u>		23B. DATE SIGNED <u>2/4/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Kenneth Krulwitz MD</u>
23D. ADDRESS <u>115 W. Monument ST.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>2/7/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy ROSARY Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>BALTIMORE M.D.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Galt, M.D.</u>	25C. FUNERAL DIRECTOR <u>RAYMOND L. KACZOROWSKI</u> ADDRESS <u>2525 FLEET ST.</u>		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

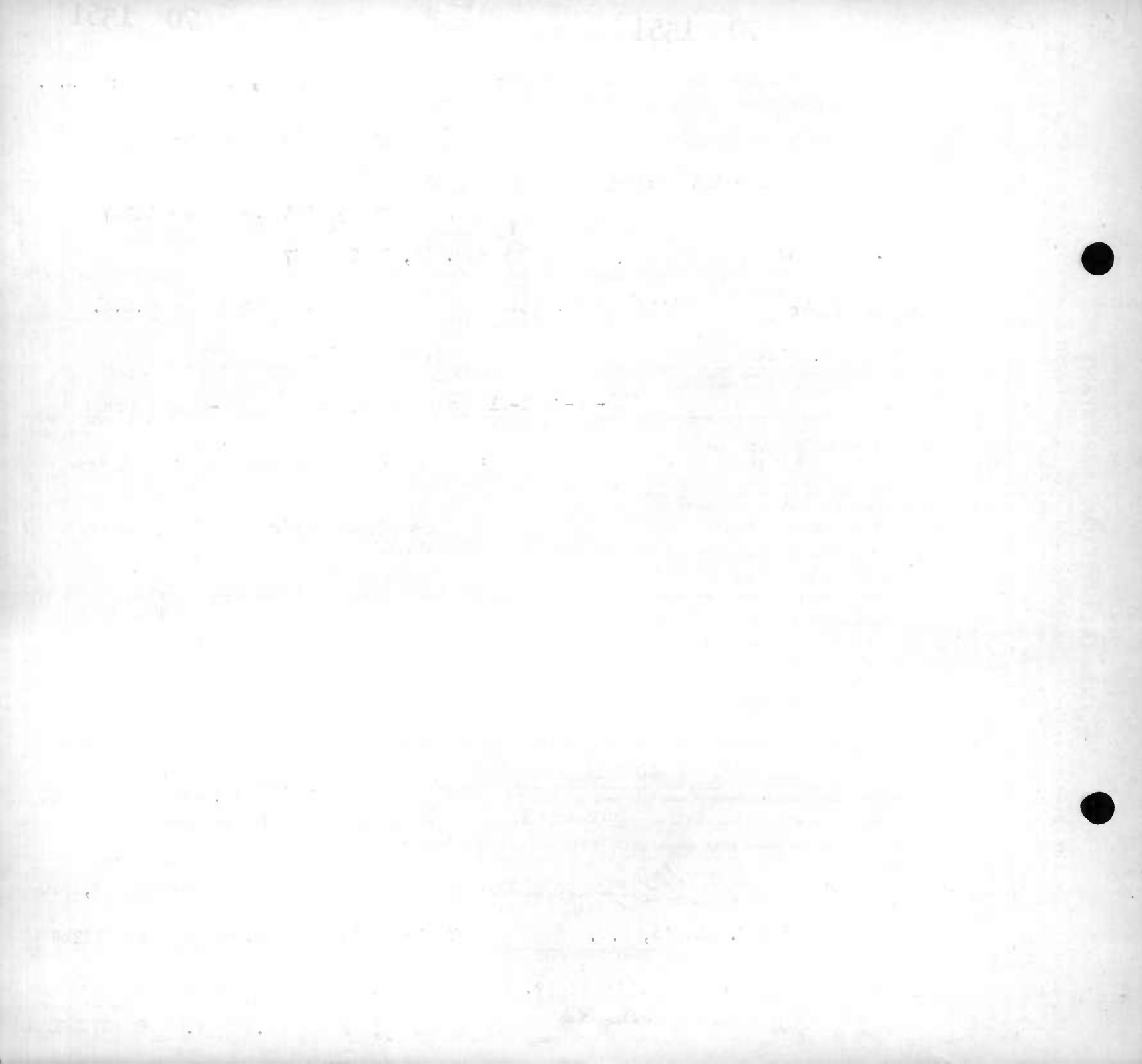
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 1550</u>	
BIRTH NO. <u>70 1550</u> <u>DERUS</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Derus George Walter</u>			2. DATE AND HOUR OF DEATH <u>Feb. 6, 70</u> <u>6:45 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home & Hospital</u> <u>35</u>			A. STATE <u>Maryland</u> B. COUNTY <u>601</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M.</u>			6. RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <u>crane operator</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>SPARROWS Pt.</u>		8. DATE OF BIRTH <u>3-10-10</u>
13. FATHER'S NAME <u>Frank Derus</u>			14. MOTHER'S MAIDEN NAME <u>Mary Ann Poswiatowski</u>		9. AGE (in years last birthday) <u>59</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>216-10-5529</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
17. INFORMANT <u>MRS. HELEN DERUS</u>			12. CITIZEN OF WHAT COUNTRY? <u>American</u>		
18. <u>3-21-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>rupture, esophageal varices</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Liver cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Liver failure, Hepatic Coma</u>		
19. DATE OF OPERATION <u>0</u>			20. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 4</u> 19 <u>70</u> to <u>Feb. 6</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>Feb. 6</u> 19 <u>70</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>T.H. L.</u>			23B. DATE SIGNED <u>Feb. 6, 70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Tsung Hsueh Lin</u>			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>2/9/70</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cem.</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore MD.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Jackson, M.D.</u>		
25C. FUNERAL DIRECTOR <u>Baron L. Kaczorowski</u>			25D. ADDRESS <u>2525 FLEET ST</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1551	
<div style="display: flex; justify-content: space-between; align-items: center;"> 70 1551 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sister Mary Joseph McGoldrick		February 7, 1970 5:40 A.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 94 Villa Saint Michael (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
			Maryland Baltimore City 2841		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			4000 Forest Hill Road 21207		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F.	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 13, 1882	87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired nurse		Sister of Charity		County Donegal, Ireland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Hugh McGoldrick			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			219-54-0601-J1		Sister Andrea -same address
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			Coronary Occlusion		1 day
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Arteriosclerosis		10 years (?)
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
none					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 159 to February 1970, that (I) (we) last saw the deceased alive on February 3, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				February 7, 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Damian P. Alagia, M.D.				3326 Frederick Avenue, Baltimore, 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2/9/70		Villa of St. Michael on the grounds Seton Institute	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 9 1970		Robert E. Taylor		SOUTHWEST & MOWEN CO. 108 W. NORTH AVE 21201	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 1552</u>
BIRTH NO. <u>70 1552</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Viola Niemczyk</u>		2. DATE AND HOUR OF DEATH <u>6-Feb-70</u> <u>9:51</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2544</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>4109 Doris Ave</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-94</u>	9. AGE (in years last birthday) <u>76</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Clothing Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Goscinski</u>		
14. MOTHER'S MAIDEN NAME <u>Julia ? Julia Kliniewski</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		
16. SOCIAL SECURITY NO. <u>219-07-2401</u>		17. INFORMANT <u>Daughter Clara McCall</u> ADDRESS <u>4109 Doris Ave</u>		
18. CAUSE OF DEATH <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Gangrene Lower Extremities</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2+ days</u> <u>30+ years</u> <u>3 months</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>(N)</u> (this hospital) attended the deceased from <u>31-Jan</u> 19 <u>70</u> to <u>6-Feb</u> 19 <u>70</u> that <u>(I)</u> (was) lost saw the deceased alive on <u>6-Feb</u> 19 <u>70</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) <u>(did)</u> (did not) view the body after death.				
23A. SIGNATURE <u>Richard E Fisher M.D.</u>				23B. DATE SIGNED <u>6-Feb-70</u>
23C. PHYSICIAN'S NAME (Type) <u>Richard E Fisher M.D.</u>		23D. ADDRESS <u>South Baltimore Gen. Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>2/10/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	25C. FUNERAL DIRECTOR <u>M. F. SADOWSKI & SONS, 1808 EASTERN AVE</u>	

VIOLA NIEMCZYK

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1553
70 1553		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) GREEN, WELBY W.		2. DATE AND HOUR OF DEATH 2-7-1970 7:15 P.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MARYLAND 730 ASHBURTON ST. BALTIMORE MD. 21216		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE B. COUNTY MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1716 W. LAFAYETTE AVE.		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1928	9. AGE (In years last birthday) 41
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) VA, Bluemont	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Welby Green		14. MOTHER'S MAIDEN NAME Heneritta Warner		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-14-7476	17. INFORMANT Mrs. Alice Green	
18. 430.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Sub Arachnoid Haemorrhage. DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension - C.V.A. DUE TO, OR AS A CONSEQUENCE OF: (C) -		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 2-5-1970 to 2-7-1970 , that (I) (we) lost saw the deceased alive on 2-7-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Prem Lal M.B., B.S.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) PREM LAL. M.B.; B.S.
23D. ADDRESS LUTHERAN HOSPITAL 730 ASHBURTON ST. BALTIMORE MD 21216		24. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 2/13/70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton E. Dyett F.H.
				ADDRESS 1701 Laurens St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1554	
BIRTH NO. 70 1554		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Teresa L. Keller			2. DATE AND HOUR OF DEATH Feb. 7, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3021 St. Paul Street		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-1885	9. AGE (in years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Annapolis Junction, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Latchford			14. MOTHER'S MAIDEN NAME Mary Fitzsimmons		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-0780	17. INFORMANT ADDRESS Mrs. Evans Insley 226 Dunkirk Road		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident 1 week (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (C) DISPOSE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Dec. 1970 to Feb. 1970 that (I) (we) last saw the deceased alive on 3 Feb. 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Com. H. Kammer, Jr.				23B. DATE SIGNED 7 Feb. 1970	
23C. PHYSICIAN'S NAME (Type) Dr. William H. Kammer, Jr.				23D. ADDRESS 6011 York Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-10-70		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 3906 York Road Balto., Md. 21212	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1555	
BIRTH NO. 70 1555		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) STEVENSON, EDDIE		2. DATE AND HOUR OF DEATH 2/6/70 9:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Balto. B. COUNTY Md.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3800 W. of Maryland Hospital		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY -		8. DATE OF BIRTH 10/27/09	
13. FATHER'S NAME -		14. MOTHER'S MAIDEN NAME -		9. AGE (In years last birthday) 60	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates at service) -		16. SOCIAL SECURITY NO. -		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
18. 303.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2/2/70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Overwhelmed Pneumonia 20A. AUTOPSY? (Yes or No) (?) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -		CAUSE OF DEATH (A) IMMEDIATE CAUSE Staphylococcal Pneumonia DUE TO, OR AS A CONSEQUENCE OF (B) Chronic Alcoholism DUE TO, OR AS A CONSEQUENCE OF (C) None		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (1) (this hospital) attended the deceased from 2/1/70 to 2/6/70 that (1) (we) last saw the deceased alive on 2/6/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE Harold J. Kaplan M.D. 23B. PHYSICIAN'S NAME (Type) HAROLD J. KAPLAN M.D. 23C. DATE SIGNED 2/6/70		23D. ADDRESS W. of Md. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/10/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton E. Dyett F.H.	
25D. LOCATION Baltimore, Maryland		25E. ADDRESS 1701 Laurens			



B-260

1

70 1556

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1556

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Irving Baker		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 466 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 2 7 70 4:40 a. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1503	
6. SEX male	7. RACE colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 1-1-1950		10. AGE (in years last birthday) 20	11. BIRTHPLACE (State or foreign country) Emporia, Virginia		12. CITIZEN OF U.S.A.
13. FATHER'S NAME Emmett Baker		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		15. MOTHER'S MAIDEN NAME Kathleen Baker	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO.		18. INFORMANT Mr. Emmett Baker ADDRESS 1808 Thomas Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E965X ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED yes 21. AUTOPSY? (Yes or No) yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Northaire and Whitmore Ave. 1503	
22D. TIME OF INJURY (APPROX.) 2 7 70 4:30 a.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE OF EXAMINER Werner U. Spitz, M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/7/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-11-70		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		25D. ADDRESS 1701 Laurens Street			

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NO 1556

70 1556

MEDICAL EXAMINER'S CERTIFICATE

DATE

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DATE

DATE

DATE

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

[Handwritten Signature]

DATE

DATE

1. NAME OF DECEASED (Type or Print) JAMES CARNEGIE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> February 5, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1718 Thomas Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour February 5, 1970 6:00 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1503	
9. DATE OF BIRTH 8-17-1894		10. AGE (In years lost birthday) 75	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 220-05-0070		18. INFORMANT ADDRESS Mable Carnegie - 1718 Thomas Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED February 5, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-70	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	

ACADEMY JUNIOR

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 1558		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1558	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HALL, CHARLES Edward		2/7/1970 5:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Lutheran Hospital			Md.		
730 Ashburton, Baltimore, Md.			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2903 Brighton Street 21216		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Male	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11-17-89	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Butler				Belair, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Quilla Hall			UNK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO.		216-28-7964		Mrs. Hortense Davis 2903 Brighton St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I			ACUTE CARDIAC FAILURE 1 hours		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			PERFORATION PEPTIC ULCER 10 hours		
(B) DUE TO, OR AS A CONSEQUENCE OF:			ATERIOSCLEROTIC HEART DISEASE YEARS.		
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2/7/70		Perforation Ulcer		-	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		-		-	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
-		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		-	
22. I certify that (I) (this hospital) attended the deceased from 2/7 1970 to 2/7 1970, that (I) (we) last saw the deceased alive on 2/7 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Samart Veehongsa				2/7/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
SAMART VEEHONGSA				Lutheran Hospital 730 Ashburton Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2/10/70		Arbutus Mem. Park Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 9 1970		Robert E. [Signature]		Morton & Dyett Felt 1701 LAUKENS	

Handwritten text, possibly a signature or name, located in the bottom left corner.

Handwritten text, possibly a date or reference number, located in the bottom left corner.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 70 1559		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1559	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>LEROY JOHNSON</u>		2. DATE AND HOUR OF DEATH <u>FEB 3, 1970 9:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Montebello State Hosp.</u> <u>91 Balt.</u>		C. CITY OR TOWN <u>BALTIMORE.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1343 N. CAREY ST. BALTO.</u>			
5. SEX <u>M</u>	6. RACE <u>N.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-26-20</u>	9. AGE (in years last birthday) <u>50</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WILMINGTON, DELAWARE</u>	
13. FATHER'S NAME <u>JOHN JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>FLORA RYDER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>162-12-2225</u>		17. INFORMANT ADDRESS	
18. <u>154.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMATOSIS -</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>1 MO -</u> <u>1 yr -</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA OF PECTUM -</u> (B) <u>1 yr -</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 MO -</u> <u>1 yr -</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES -</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-28-70</u> 19 <u>70</u> to <u>2-5</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2-5</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Raymond W. Herrmann</u>		23B. DATE SIGNED <u>2/5/70</u>		23C. PHYSICIAN'S NAME (Type) <u>RAYMOND W. HERRMANN</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>2-12-70</u>		24C. NAME of CEMETERY or CREMATORY <u>HAVEN MEM. PARK</u>	
24D. LOCATION (City, town, or county) (State) <u>FELTONVILLE, DELAWARE CO.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert C. Taylor</u>	
25C. FUNERAL DIRECTOR <u>CATHERINE B. LAWS</u>		25D. ADDRESS <u>2126 W 4th St.</u>		25E. CITY <u>PHILADELPHIA PA.</u>	



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B-623

1. NAME OF DECEASED (Type or Print) Emmitt L. Bookins		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS AND LOCATION) Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 2 7 70 8:10 a.m.	
6. SEX male		7. RACE colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1403	
9. DATE OF BIRTH 3/10/13		10. AGE (In years lost birthday) 56	
11. BIRTHPLACE (State or foreign country) Pittsburgh PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		13. FATHER'S NAME Emmitt C. Brookins	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW II		17. SOCIAL SECURITY NO.	
18. INFORMANT William Brookins		ADDRESS 1740 Park AVE	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2			
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. DATE SIGNED: 2/7/70 EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/11/70	
24C. NAME OF CEMETERY or CREMATORY Allegheny		24D. LOCATION (City, town, or county) (State) Pittsburgh PA.	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.	
25C. FUNERAL DIRECTOR Spriggs & Watson		ADDRESS F.H. Pittsburgh PA.	

1/24/15 - Notarized statement from Stan. Broofeni that he was in
error when he is marital status. (2) Certified Copy
of marriage lic. Jfc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 70 1561	
E-152 BIRTH NO. 70 1561		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) MRS. HELEN D. EVANS		2. DATE AND HOUR OF DEATH 2/5/1970 8:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 Maryland Gen. Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3516 Beech Ave.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2/3/1918
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk.	10B. KIND OF BUSINESS OR INDUSTRY MD. NATIONAL Bank (clerk)	11. BIRTHPLACE (State or foreign country) Baltimore Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph DRAWDWILA		14. MOTHER'S MAIDEN NAME MARCELLA SAKOVICH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-4563	
17. INFORMANT MRS. L. KEMPER OWENS		ADDRESS 221 Edgevale Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Malignant Melanosis		CAUSE OF DEATH Carcinoma of the Rectum	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/4 19 70 to 2/5 19 70 , that (I) (we) last saw the deceased alive on 2/5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE M. S. AL-IBRAHIM M.D.		23B. DATE SIGNED 2/5/1970	
23C. PHYSICIAN'S NAME (Type) M. S. AL-IBRAHIM M.D.		23D. ADDRESS md - Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/7/70	
24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md. 21212	

1951-52

1951-52

12

W/D - WATERMAN
W/D - WATERMAN

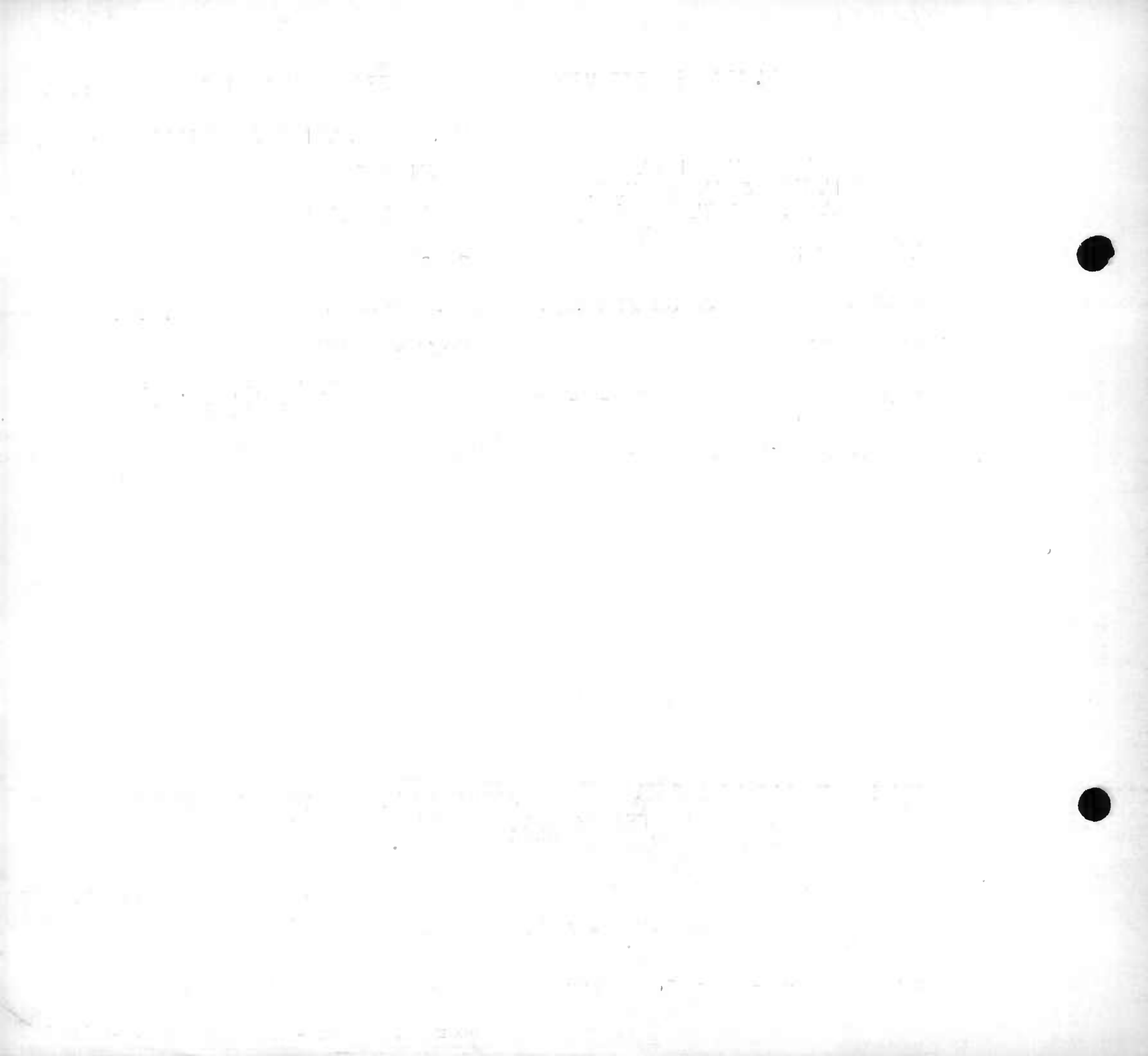
THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE
NEW YORK 17, N.Y.

1951-52

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO.	
11-220 70 1562		CERTIFICATE OF DEATH		70 1562	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MOSES, ERNEST VERNON		FEBRUARY 7, 1970 4:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE B. COUNTY	
40 ST AGNES HOSPITAL WILKENS & CATON AVES. BALTO., MARYLAND 21229				MDI. BALTIMORE 21227 5300	
5. SEX		6. RACE		C. CITY OR TOWN	
MALE		WHITE		BALTIMORE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS?	
8. DATE OF BIRTH		9. AGE (In years last birthday)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19-08-17		52			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER	
MANAGER		CITGO GAS STATION		1013 CIRCLE DRIVE	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
NORTH CAROLINA		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
ISAAC MOSES		XXXXXXX Martha			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes no		246-14-2704		BALTIMORE, MD. 21229 ST AGNES RECORDS WILKENS & CATON AVES.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
574.1 I		NOT ESTABLISHED. POSS. CARDIAC ARREST.		LESS THAN ONE HOUR.	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		1) CHOLECYSTITIS / CHOLELITHIASIS 2) POLYCYTHEMIA		NOT WELL ESTABLISHED.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1/23/70 - 2/3/70		GALL BLADDER DISEASE AND PERITONEAL ADHESIONS		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		JANUARY 14, 1970		FEBRUARY 7, 1970	
that (I) (we) last saw the deceased alive on		FEBRUARY 7, 1970		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
JULIO FREIJANES, MD.		23D. ADDRESS		FEBRUARY 2, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2-10-70		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
FEB 9 1970		Howard H. Hubbard		ADDRESS	
				4107 Wilkens Ave-21229	



F-652 70 1563

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1563

BIRTH NO.

1. NAME OF DECEASED (Type or Print) III ANTHONY FRENCH				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 2 Day 8 Year 1970 Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital				3. DATE PRONOUNCED DEAD Month 2 Day 8 Year 70 Hour 2:30 P. M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6-24-1922				10. AGE (In years last birthday) 47		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF U.S.A				13. FATHER'S NAME William French			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				14B. KIND OF BUSINESS OR INDUSTRY R & S Sales Co. Auto parts			
15. MOTHER'S MAIDEN NAME Carrie Mar11				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			
17. SOCIAL SECURITY NO. 214-14-4085				18. INFORMANT Christina French			
19. CAUSE OF DEATH E 81210 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2-4-70				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Md. Rt. 175-Jessop, 200' from Dorsey Run Rd.			
22D. TIME OF INJURY (APPROX.) 2-4-70 3:50 P. m.				22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Driver in auto-auto collision.				23.			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 2-9-70				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 2-12-1970				24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery			
24D. LOCATION (City, town, or county) (State) Balto. Md				25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.				25C. FUNERAL DIRECTOR H. Hubbard Funeral Home			
ADDRESS 4107 Wilkens Ave							

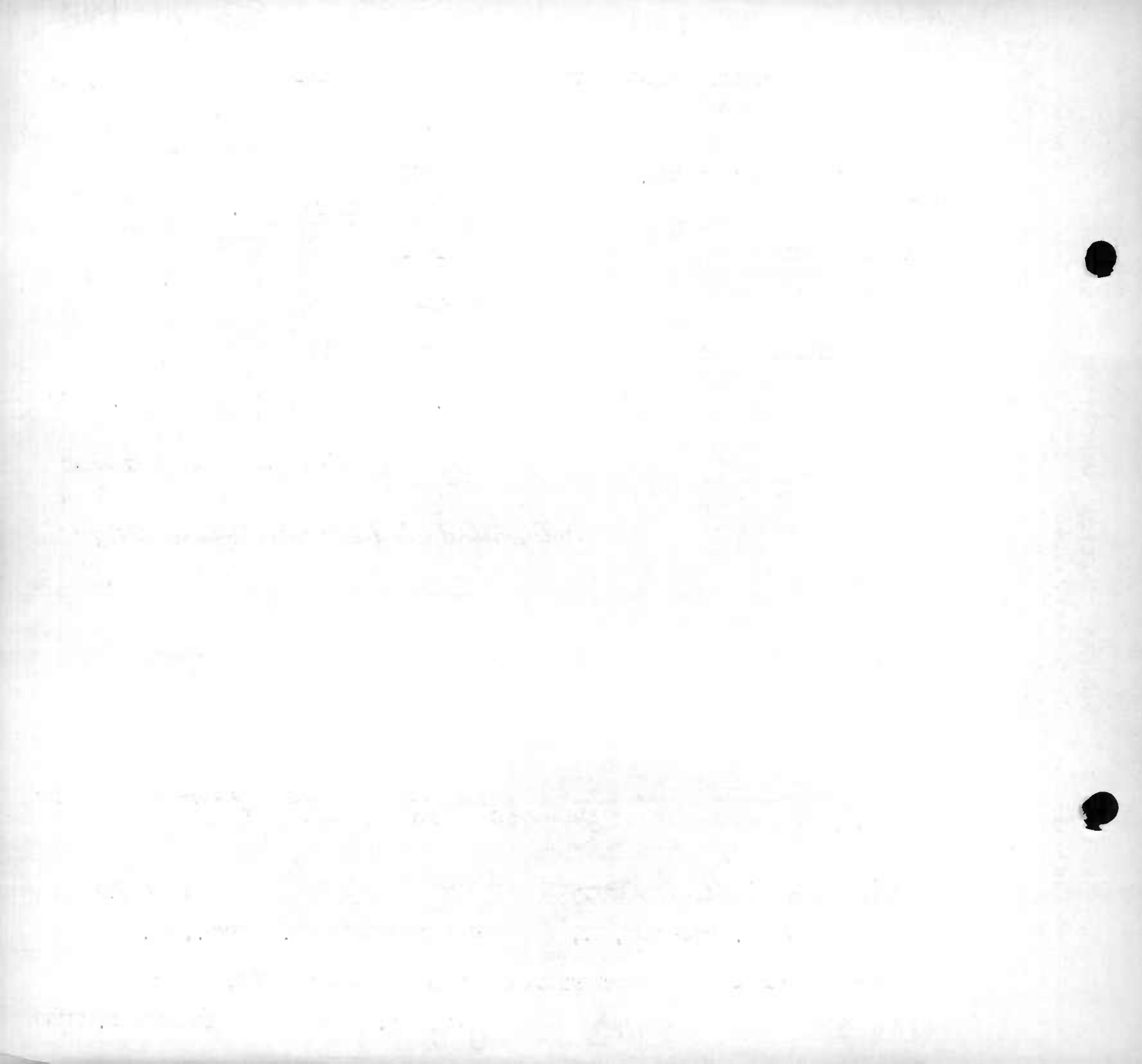
7

APPROXIMATE ESTIMATE OF DAILY

FUNERAL DIRECTOR: IMPORTANT

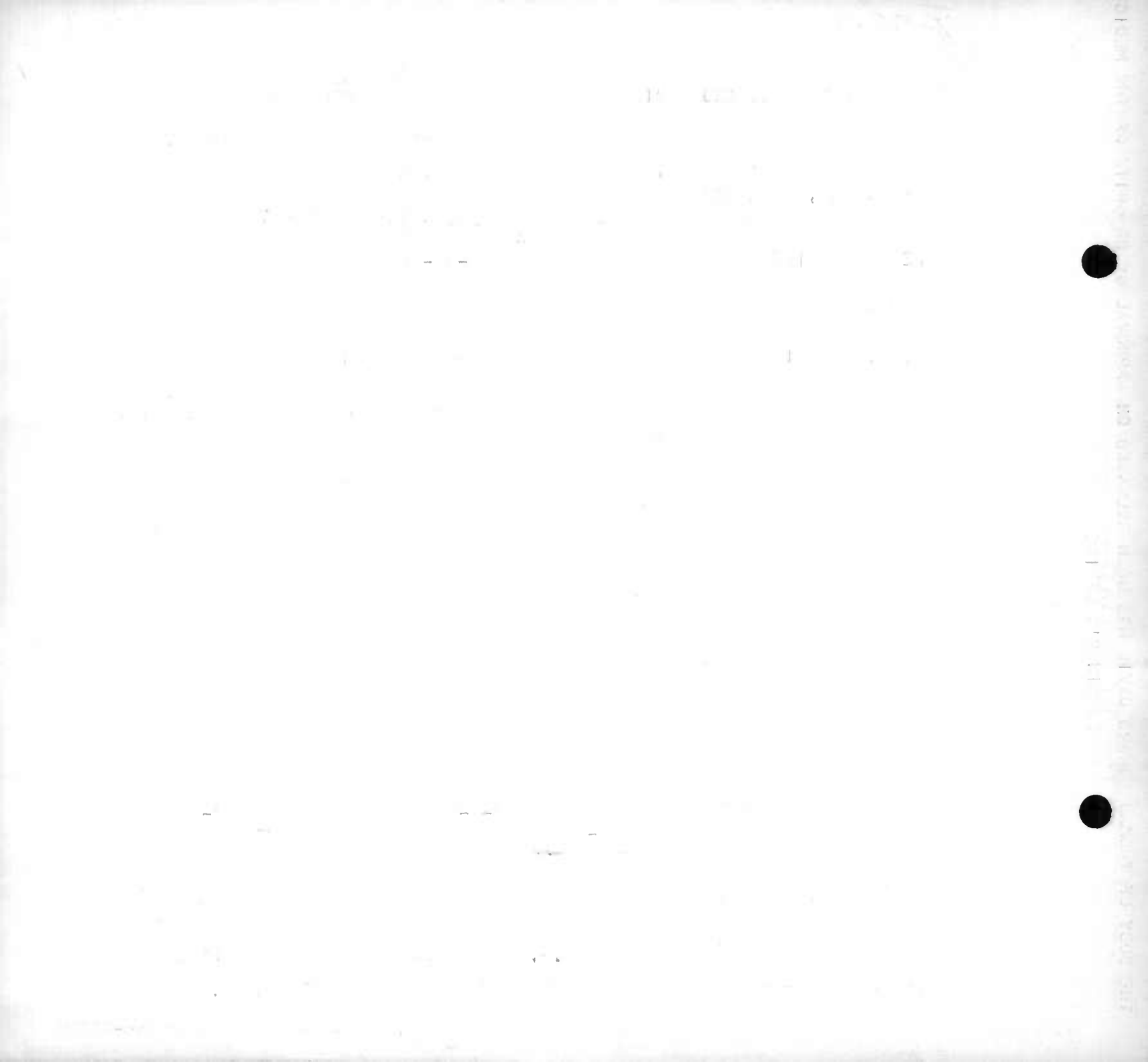
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
B-400		70	1564	70 1564	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
NETTIE MABEL BAILEY			2-7-70 1 01 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
1429 WASHINGTON BLVD.			MARYLAND 2102		
5. SEX			6. DATE OF BIRTH		9. AGE (In years lost birthday)
FEMALE WHITE			6-24-90		79
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			10. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MARYLAND		USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			14. MOTHER'S MAIDEN NAME		
HOMEMAKER			SARAH HARRISS		
13. FATHER'S NAME			16. SOCIAL SECURITY NO.		
MILLARD SOUTH			212075332		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			17. INFORMANT ADDRESS		
NO			MRS. GEORGE BRENNAN 24 NUNNERY LN. 21228		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			2 mo.		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Myocardial Discompensation		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Anterior wall of Cardio Vascular System		
			(C) 20 yrs.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (The hospital) attended the deceased from Jan 12 1942 to Feb 7 1970, that (I) (we) last saw the deceased alive on Jan. 30 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
WILMER K. GALLAGHER, SR.				2-9-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
WILMER K. GALLAGHER, SR.				6209 FREDERICK AVE. BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		2-10-70		CHESTERFIELD CEMETERY	
				24D. LOCATION (City, town, or county) (State)	
				CENTREVILLE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 9 1970		Howard H. Hubbard		HOWARD H. HUBBARD 4107 WILKENS AVE. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 1565	
BIRTH NO. 70 1565		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) THOMAS EDWARD DAVIS		2. DATE AND HOUR OF DEATH 2/7/70 255 P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		B. COUNTY TALBOT	
ADDRESS OR LOCATION BALTIMORE, MD 21205		C. CITY OR TOWN EASTON		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 505 HOLLYDAY STREET					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-07-70	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME WILLIAM DAVIS		14. MOTHER'S MAIDEN NAME CHARLOTTE MILLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WILLIAM DAVIS, 505 Hollyday St. Easton, Md. 21601	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Distress Syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Respiratory Distress Syndrome		(B) DUE TO, OR AS A CONSEQUENCE OF: Myelene Mens. Disease		(C) ?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2-7-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-7-70 to 2-7-70 and that (I) (we) last saw the deceased alive on 2-7-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Wm G Bartholome		23B. DATE SIGNED 2/7/70		23C. PHYSICIAN'S NAME (Type) William G. Bartholome	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-70		24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY	
24D. LOCATION BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Ave-21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

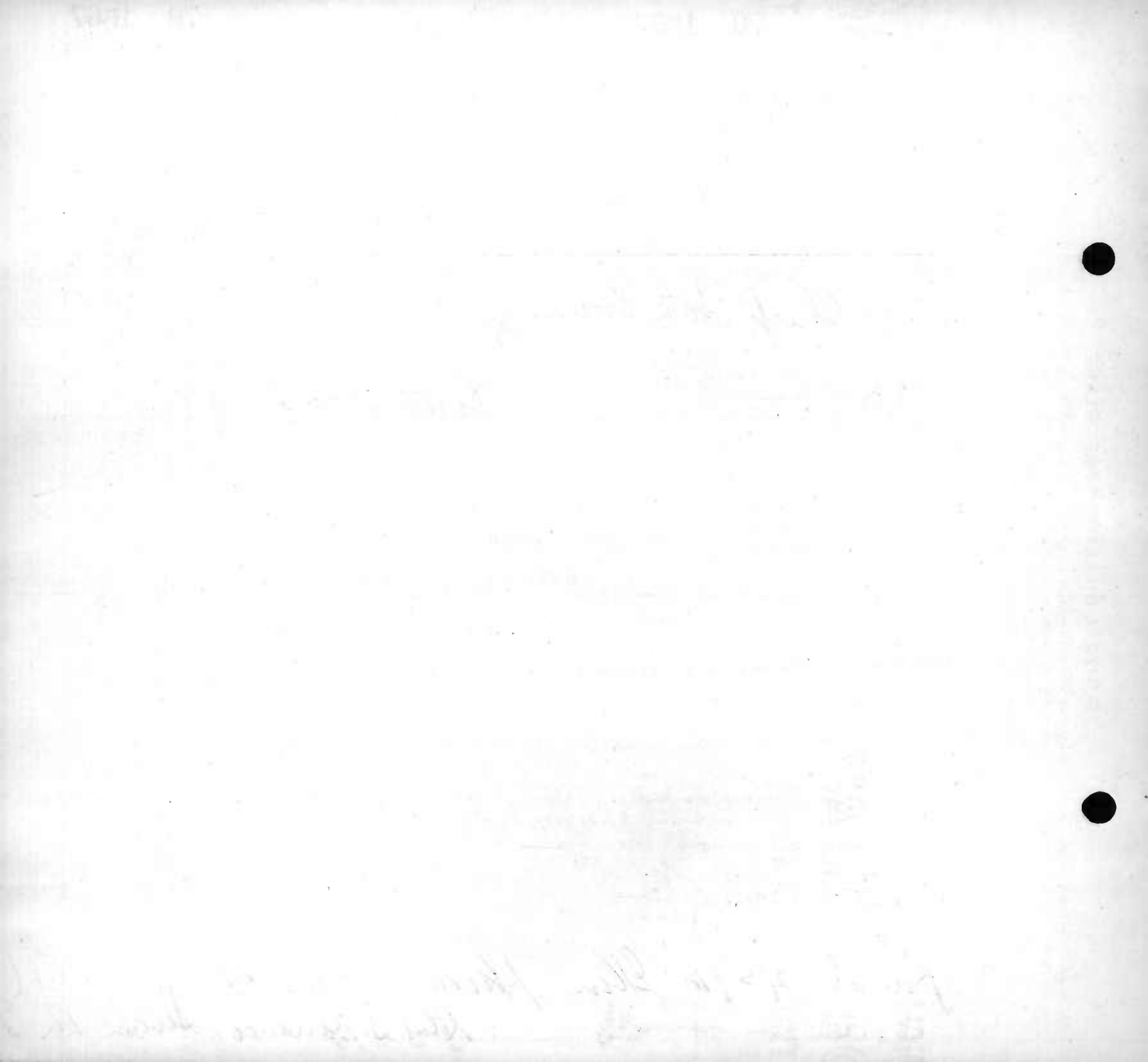
BIRTH NO. L-563				BALTIMORE CITY HEALTH DEPARTMENT				70 1566				REG. NO. 70 1566			
1. NAME OF DECEASED (Type or Print) John Edwards Leonard								2. DATE AND HOUR OF DEATH 216 710 112:35 P M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD University of Maryland Hosp								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hosp								C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 636 Portland St															
5. SEX M		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/28/13		9. AGE (in years last birthday) 56		11. Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? USA			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER								10B. KIND OF BUSINESS OR INDUSTRY Fruit Co.				11. BIRTHPLACE (State or foreign country) North Carolina			
13. FATHER'S NAME Unknown								14. MOTHER'S MAIDEN NAME Unknown							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 139-05-1919				17. INFORMANT Abbie Brown 636 Portland St ADDRESS Dorothy Bennett 306 h Schroeder St							
18. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.															
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Alcohol															
19A. DATE OF OPERATION 2/10/70				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (X) (this hospital) attended the deceased from 215 19 70 to 216 19 70 that (X) (we) last saw the deceased alive on 216 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.															
23A. SIGNATURE Carol Lee Koski MD DEGREE								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 216 710			
23C. PHYSICIAN'S NAME (Type) CAROL LEE KOSKI MD DEGREE								23D. ADDRESS Univ. of Md Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 2/10/70				24C. NAME OF CEMETERY or CREMATORY Int Auburn				24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR Charles A. Rue				ADDRESS 661 W. Barre St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-630		70 1567		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 1567	
1. NAME OF DECEASED (Type or Print) FORD, Vernon A.				2. DATE AND HOUR OF DEATH 2/3/70 12:00 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundle C. CITY OR TOWN Severna Park D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Rt. #1, Box 198-C			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/23/06	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired Chief Data Processing		10B. KIND OF BUSINESS OR INDUSTRY Data Processing		11. BIRTHPLACE (State or foreign country) Ind		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Ford				14. MOTHER'S MAIDEN NAME Claudia Rice			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Dorothy Ford - Above		ADDRESS	
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSION, ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: UREMIA, ? CVA (C) Chronic Lung disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Lung disease							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from February 1, 1970 to February 2, 1970 , that (I) (we) last saw the deceased alive on February 2, 11 PM 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harvey G. Klein				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED February 3, 1970	
23C. PHYSICIAN'S NAME (Type) Harvey G. Klein, M.D.				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/5/70		24C. NAME OF CEMETERY or CREMATORY Green Haven		24D. LOCATION (City, town, or county) (State) Green Berne Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Robert S. Binnico		ADDRESS Severna Park	



70 1568

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 1568

BIRTH NO. _____ REG. NO. _____

1. NAME OF DECEASED (Type or Print) CECILIA B. LAKE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> February 5, 1970 12:10 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 John Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year February 5, 1970 12:10 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN ANNAPOLIS	
9. DATE OF BIRTH 7-1-04		10. AGE (in years last birthday) 68	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife @ home		14B. KIND OF BUSINESS OR INDUSTRY @ home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. -	
18. INFORMANT Miss Janice Lake - @ home		ADDRESS -	
19. CAUSE OF DEATH 48191		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Intracerebral hemorrhage		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		DATE SIGNED February 5, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/9/70	
24C. NAME OF CEMETERY OR CREMATORY Calverton Cemetery		24D. LOCATION (City, town, or county) (State) N.Y.	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Baker	
25C. FUNERAL DIRECTOR Robert E. Baker		ADDRESS -	

VS 151-REV. 7/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-362 70 1569		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1569	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WILLIE MAE STARKS		2-6-70		9:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
39 PROVIDENT HOSPITAL		MARYLAND		1501	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1550 N. FREMONT AVE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. Months Days
FEMALE	NEGRO	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3-6-1876	98	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				ALABAMA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
(NOT KNOWN)		(NOT KNOWN)		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				WILLIE MAE PENN - SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		PNEUMONIA WITH DAYS	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:		fluid accumulation (L)	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ARTERIOSCLEROTIC GANGRENE		DAYS	
		DUE TO, OR AS A CONSEQUENCE OF:		Rt. lower extremity	
		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
FEB 2, 1970		gangrene Rt. leg		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work			
22. I certify that (I) (this hospital) attended the deceased from		Jan 27 1970 to Feb 6 1970			
that (I) (we) last saw the deceased alive on		Feb 6 1970		and that (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Manuel J. Tan		Feb 6 / 70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MANUEL J. TAN					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		2-11-70		CHARTIERS CEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
FEB 10 1970		Robert E. Bailey		V. R. BAILEY	
				ADDRESS	
				KEYSONE B. 1348 CALHOUN ST.	

RESIDENT HOSPITAL

LEWIS NEGRO

X

3-2-18 118

1225 N TOWN ST

HARTFORD

X

ALABAMA

11 2 11

(NOT KNOWN)

(NOT KNOWN)

WHITE MALE

WESTMINSTER, DOWNEY ROAD
127 Lower East
ALABAMA
found documents (1)
GENERAL WITH
TAX

First stage of disease 1st and 2nd

MARCEL 9-10
JANUARY 10

X

Feb 10/10

Jan 10

to

Feb 10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

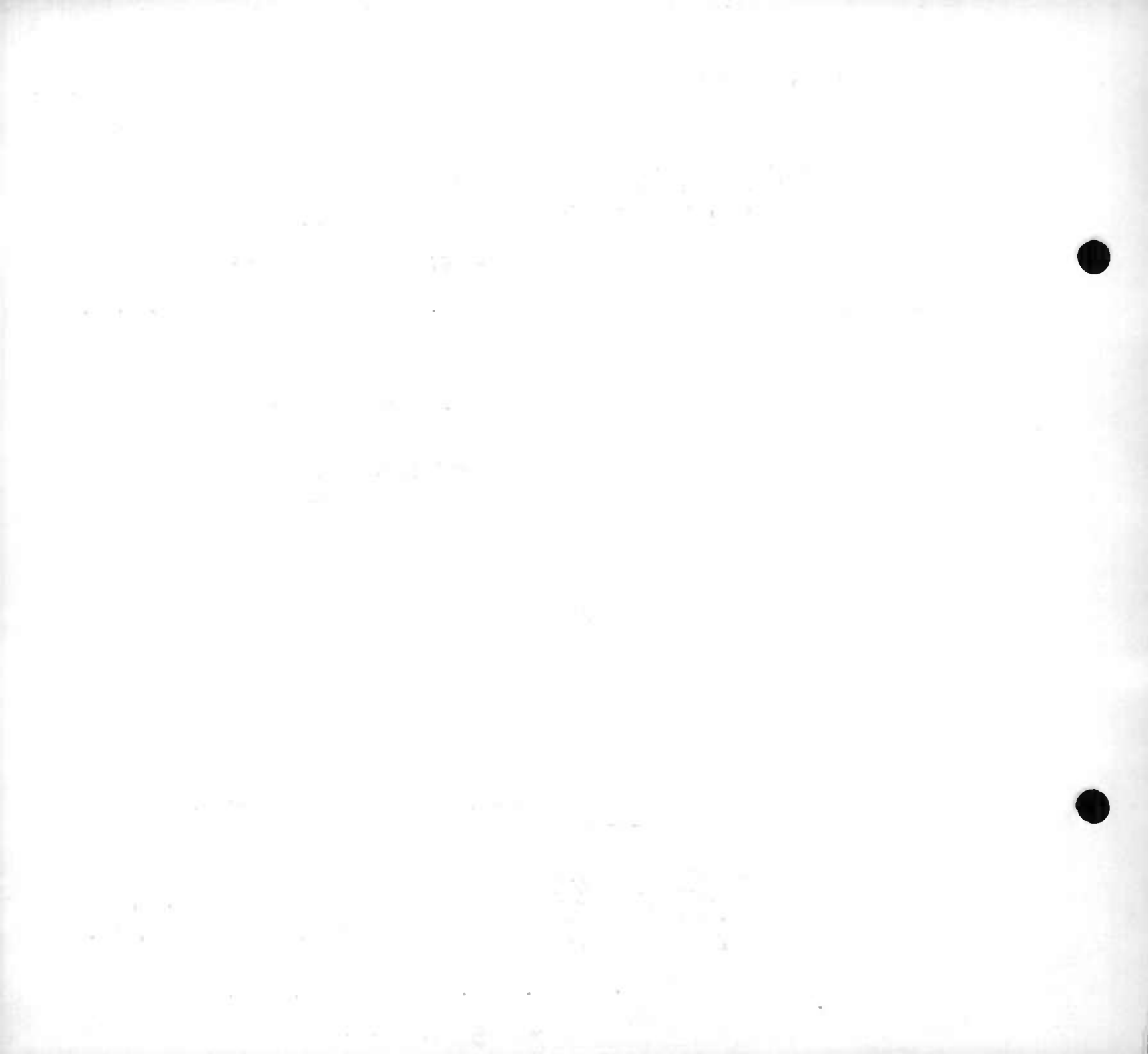
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 1570</u>	
<div style="display: flex; justify-content: space-between;"> W-623 70 1570 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>CHESTER A. WRIGHT</u>		2. DATE AND HOUR OF DEATH <u>2/6/70</u> <u>12¹⁰ A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 MONTEBELLO STATE HOSP BALTO</u>		C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3118 Balto St. BALTO</u>			
5. SEX <u>M.</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-25</u>	9. AGE (in years last birthday) <u>44</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
13. FATHER'S NAME <u>JAMES WRIGHT</u>		14. MOTHER'S MAIDEN NAME <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES 11/3/43 - 1/6/46</u>		16. SOCIAL SECURITY NO. <u>219-14-2596</u>		17. INFORMANT <u>HILDA WRIGHT - WIFE - SAME</u>	
18. <u>25019 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRAL HEMORRHAGE</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>DIABETIC NEPHROPATHY</u>		<u>4 YRS</u>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>DIABETES MELLITUS</u>		<u>7 YRS - SEVERE</u>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-11</u> 19 <u>69</u> to <u>2-6</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2-6</u> 19 <u>70</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Raymond W. Herrmann</u>				23B. DATE SIGNED <u>2/6/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>RAYMOND W. HERRMANN</u>				23D. ADDRESS <u>MONTEBELLO STATE HOSP BALTO</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>2-9-70</u>		24C. NAME of CEMETERY or CREMATORY <u>BALTO. NAT'L. CEM.</u>	
24D. LOCATION <u>BALTO. 5000</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey</u>		25C. FUNERAL DIRECTOR <u>V.R. BAILEY</u> ADDRESS <u>DEERSON B.H. 1345 N. CALHOUN ST.</u>	



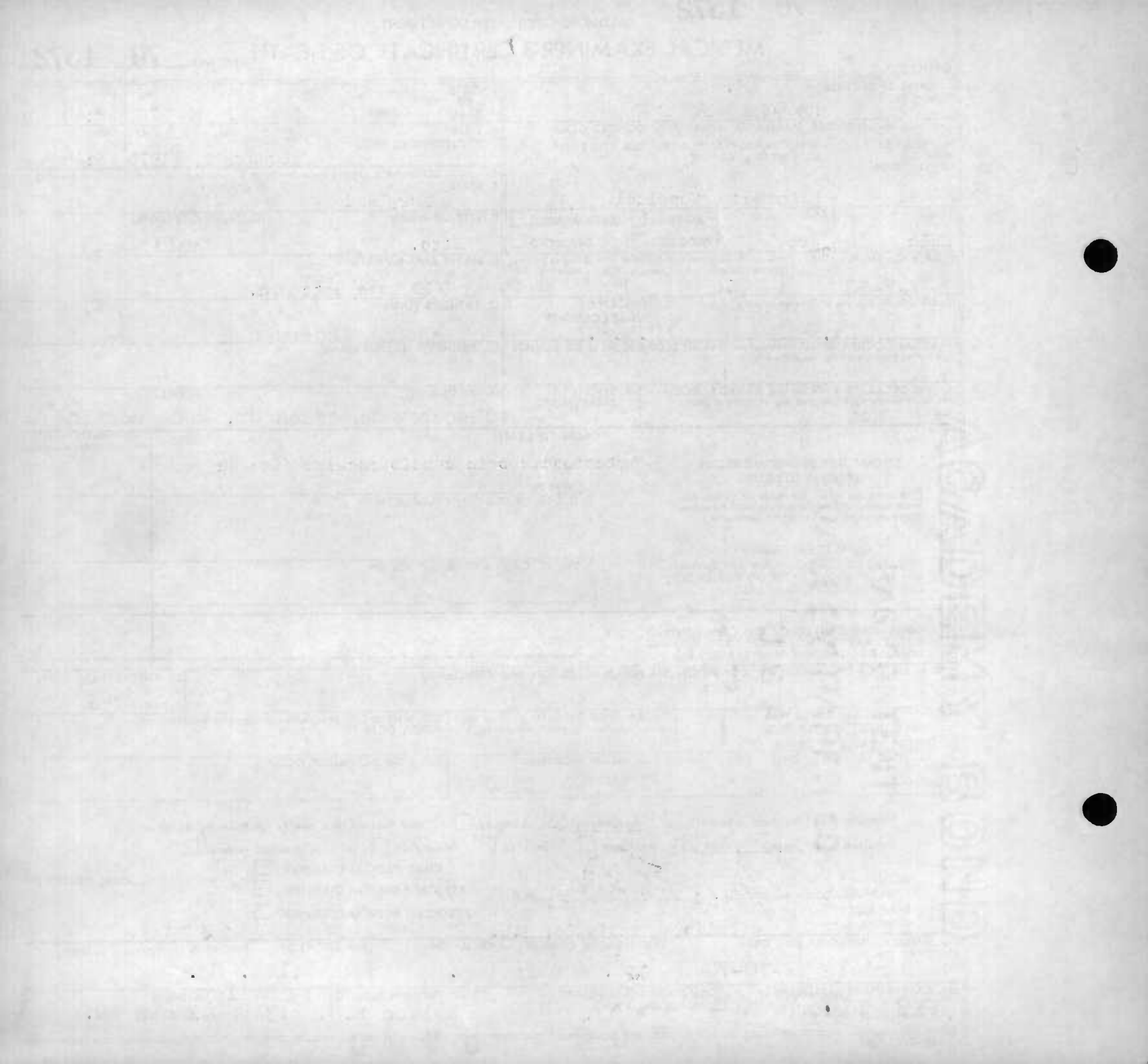
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 1571	
CERTIFICATE OF DEATH				REG. NO. 70 1571	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Joiner, Columbus		2. DATE AND HOUR OF DEATH 2-4-70 8:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 1703			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Divison Street Baltimore, Maryland 21217		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 6-3-01	
13. FATHER'S NAME Dan Joiner		14. MOTHER'S MAIDEN NAME Rebecca		9. AGE (In years last birthday) 68 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 9-26-18* 1-8-19		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Ala.	
17. INFORMANT Mrs. Bertha Joiner-Wife		ADDRESS Same		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hodgkins Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary Edema					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-4-70 19 to 2-4-70 19 that (I) (we) lost saw the deceased alive on 2-4-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Tengco MD		23B. DATE SIGNED Feb. 5, 1970		23C. PHYSICIAN'S NAME (Type) G. Tengco MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-70		24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem.	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Bailey, Jr.		25C. FUNERAL DIRECTOR V.R. Bailey	
				ADDRESS 1348 Calhoun Street	



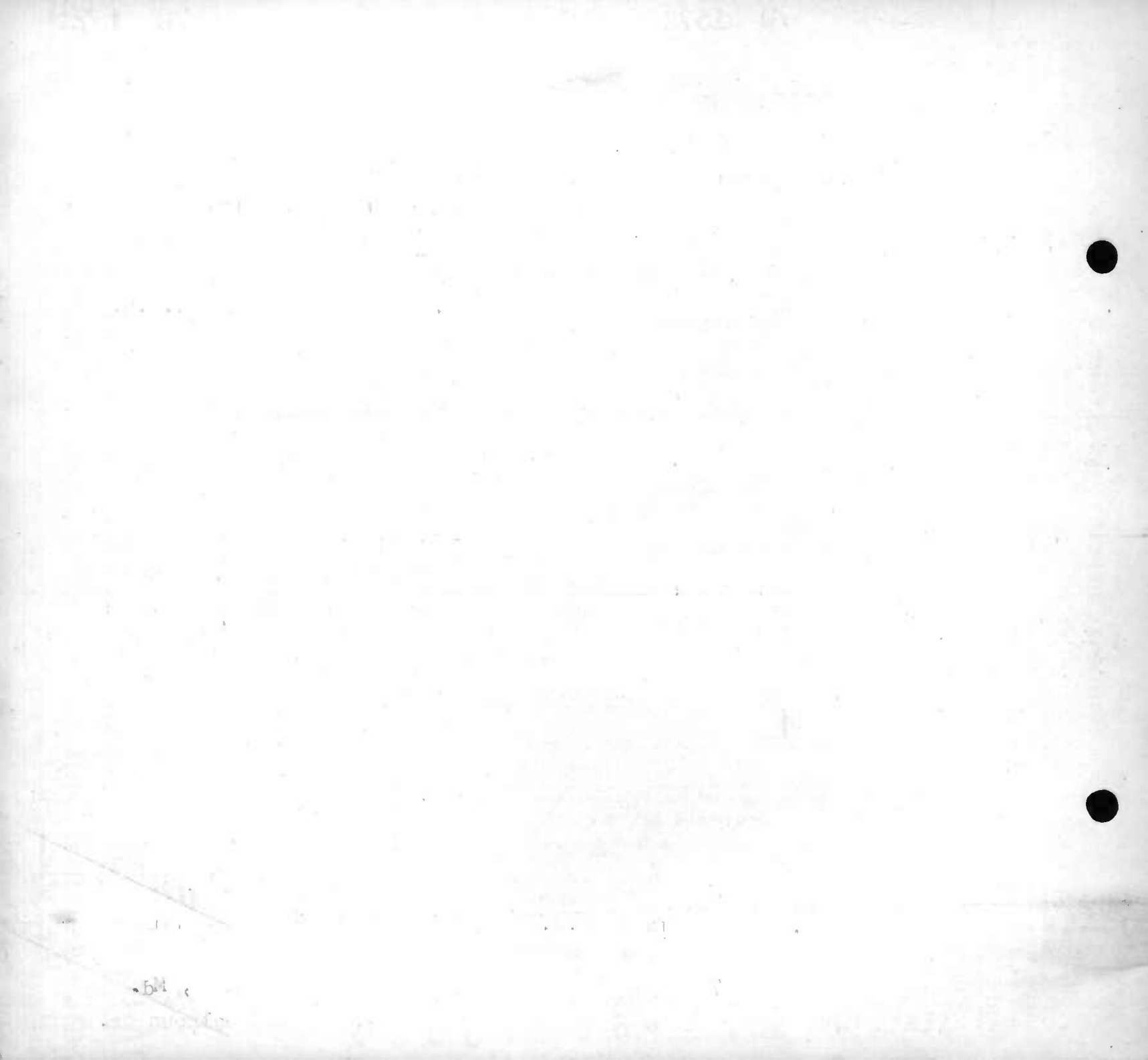
1. NAME OF DECEASED (Type or Print) <u>THEODORE ANDERSON</u>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month <u>2</u> Day <u>5</u> Year <u>70</u> Hour <u>6:40</u> p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>76 Lutheran Hospital</u>		3. DATE PRONOUNCED DEAD Month <u>February</u> Day <u>5</u> Year <u>1970</u> Hour <u>6:40</u> p.m.	
6. SEX <u>Male</u>		7. RACE <u>Negro</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1603</u>	
9. DATE OF BIRTH <u>1-7-00</u>		10. AGE (In years lost birthday) <u>70</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Anderson</u>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <u>Theodore Anderson Jr. 2206 Roslyn</u>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Arteriosclerotic cardiovascular disease</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 20A. DATE OF OPERATION <u>0</u> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) <u>no</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Isidore Mihalakis</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Isidore Mihalakis, M.D.</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2/6/70</u> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-10-70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		25B. NAME OF REGISTRAR <u>Kelson F.H.</u>	
25C. FUNERAL DIRECTOR <u>V Bailey</u>		ADDRESS <u>1348 Calhoun St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.		70 1573	
BIRTH NO. H-650 70 1573				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FLORECE FLORENCE Ann Hearn				2. DATE AND HOUR OF DEATH 2-5-70 5:55 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 1512			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2316 DRUID PARK DRIVE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-30-37	9. AGE (In years last birthday) 32	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Briscoe Washington				14. MOTHER'S MAIDEN NAME Gertrude Brisco			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-34-6951		17. INFORMANT Melvin Beans		ADDRESS 846 Glenwood Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Respiratory Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Aspiration Pneumonia (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). —				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 17 1970 to Feb 5 1970, that (I) (we) last saw the deceased alive on Feb 5 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE N. Rosenshein				23B. DATE SIGNED 5 Feb 70		23C. PHYSICIAN'S NAME (Type) N. ROSENSHEIN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 2-11-70		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970			
25B. NAME OF REGISTRAR Kelson F.H.				25C. FUNERAL DIRECTOR V. Bailey			
25D. ADDRESS 1348 Calhoun St.							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
70 1574				70 1574	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>William H. Pridgen</u>			2. DATE AND HOUR OF DEATH <u>2/9/70</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balt city</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hosp</u> <u>38 Baltimore, Md.</u>			C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>June 10, 1918</u>		9. AGE (in years lost birthday) <u>51</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Boat. Store Co</u>		11. BIRTHPLACE (State or foreign country) <u>N. C. Rutherford</u>
13. FATHER'S NAME <u>William Pridgen</u>			14. MOTHER'S MAIDEN NAME <u>Leonora Taylor</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Duff Sheet</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u>			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>interocutaneous fistula</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>post-operative bowel</u>		
			(C) <u>multiple ulcerations</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>multiple ulcerations</u>					
19A. DATE OF OPERATION <u>1-7-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>chronic fistula + abscess</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>2-1</u> 19 <u>70</u> to <u>2-9</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>2-9</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard H. Reed MD</u>			23B. DATE SIGNED <u>2-9-70</u>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burn</u>		24B. DATE <u>2/11/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MA Calvary</u>	
24D. LOCATION (City, town, or county) (State) <u>Brownlee MD 21225</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor MD</u>	
25C. FUNERAL DIRECTOR <u>Major John P. Hays</u>		25D. ADDRESS <u>628 n. glenn</u>			

2201 Argonne Dr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT BIRTH NO. 70 1575 CERTIFICATE OF DEATH Registered No. 70 1575				
M.E. CASE NO. _____ 1. NAME OF DECEASED (Type or Print) Arthur B Jones Sr		2. DATE AND HOUR OF DEATH Feb 6, 1970		M. _____
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY 1305 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3135 Keswick Rd 21211		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 21, 1912	9. AGE (In years lost birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pump Operator		10B. KIND OF BUSINESS OR INDUSTRY Balto City	11. BIRTHPLACE (State or foreign country) Westernport, Md	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Jones		14. MOTHER'S MAIDEN NAME Guy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	17. INFORMANT ADDRESS Gerald W Jones 4350 Rear 6th St 21225	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) concordia DUE TO _____ (B) arteriosclerosis DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH _____
MEDICAL CERTIFICATION				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	20A. AUTOPSY? (Yes or No) _____	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____		
22. I certify that (I) (this hospital) attended the deceased from October 1953 to Jan. 20 1970 , that (I) (we) last saw the deceased alive on Jan. 20 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Eugene Schnitzer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 2-9-70	
23C. PHYSICIAN'S NAME (Type) EUGENE SCHNITZER		23D. ADDRESS 3904 S. HANOVER ST. BALTO. MD. 21225		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/10/70	24C. NAME of CEMETERY or CREMATORY Headsville Cemetery	24D. LOCATION (City, town, or county) (State) Keyser W.Va.	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher	25C. FUNERAL DIRECTOR ADDRESS McBally F.H. 237 Patapsco ave 21225	

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Section 6

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 1576	
C-636 70 1576							
BIRTH NO.				1. NAME OF DECEASED (Type or Print) CARTER, ROBIN		2. DATE AND HOUR OF DEATH 2/8/70 1:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY BALTO. CO.			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 1814 Perrywood Rd. # 34			
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-61	9. AGE (In years last birthday) 8	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD T. Carter				14. MOTHER'S MAIDEN NAME BARBARA Bassford			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital records		ADDRESS	
18. 223.0 I CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ASPIRATION				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CYSTIC FIBROSIS				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C).....			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pneumonia							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from 1-28 19 70 to 2-8 19 70 , that (I) (we) last saw the deceased alive on 2-8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE D. Colin Kelly				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2-8-70	
23C. PHYSICIAN'S NAME (Type) P. Colin Kelly M.D.				23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/12/70		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Kelly		25C. FUNERAL DIRECTOR C. F. EVANS & SON		ADDRESS 8802 Harford Rd.	

SINAI HOSPITAL

F White

EDWARD

BARBARA
MARLEND

8-7-61

1814 Broadway St N.W.

ASPIRATION

GASTRIC FIBROSIS

PHENOL

HC

D. Robin Kelly

1-28-61

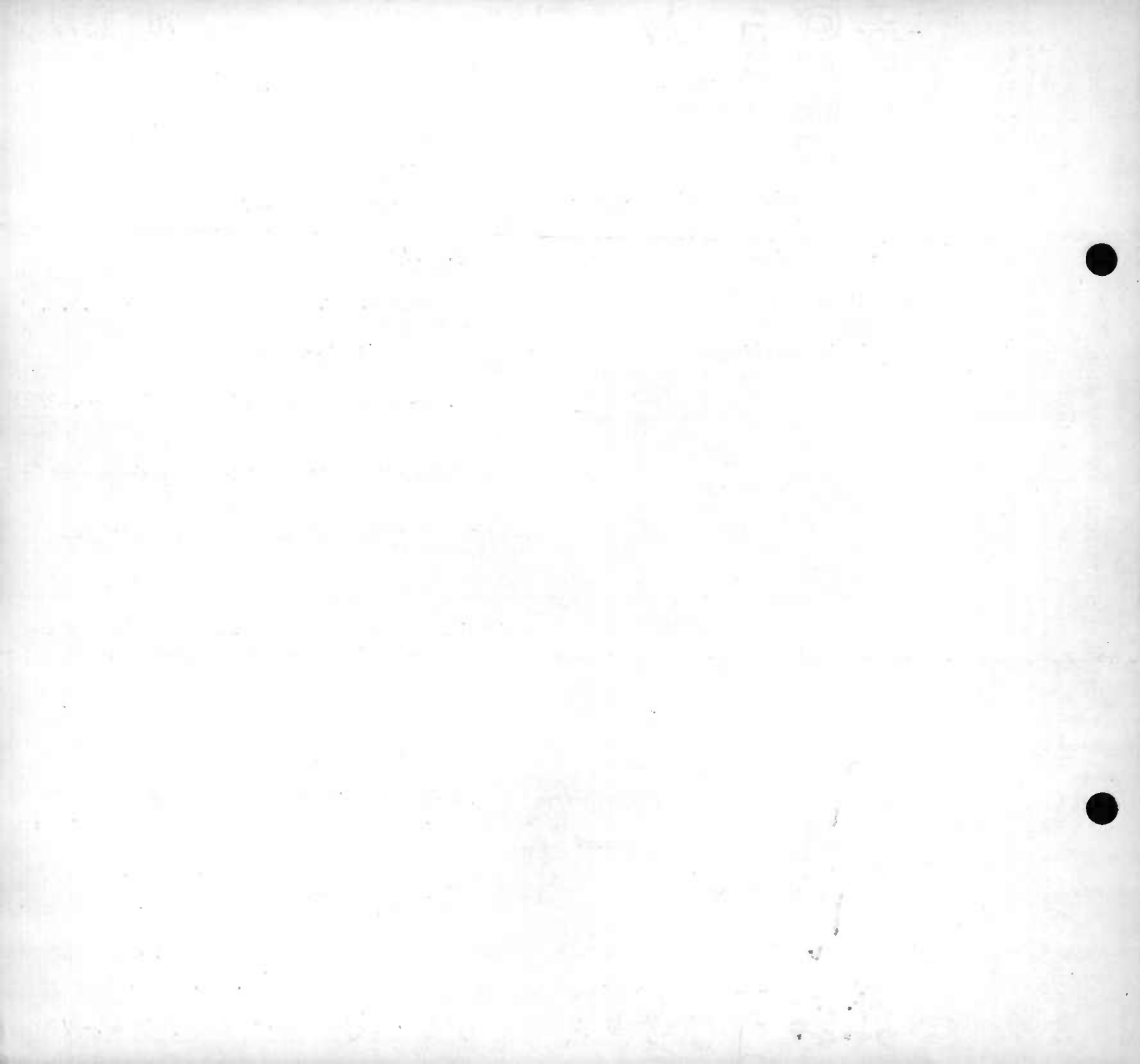
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2-7-70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-156				70 1577				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1577			
1. NAME OF DECEASED (Type or Print)								2. DATE AND HOUR OF DEATH							
Grace Spinner								February 6, 1970							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland				B. COUNTY 2631			
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 5903 Kavan Avenue-21206							
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 5, 1889		9. AGE (In years last birthday) 80		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Balto. Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Workinger								14. MOTHER'S MAIDEN NAME Elizabeth Schenkle							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -				17. INFORMANT ADDRESS Mrs. Grace Langham- 5911 Greenhill Ave.-21206							
18. 731.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ante mortem								CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral hemorrhage				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 yrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II								(B) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:							
(C) Arterio sclerosis															
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).															
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from July 19 69 to Feb. 19 70 , that (I) (we) last saw the deceased alive on Oct. 1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
23A. SIGNATURE Michael								23B. DATE SIGNED							
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 2-9-70				24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery				24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970								25B. NAME OF REGISTRAR Robert E. [Signature]				25C. FUNERAL DIRECTOR ADDRESS John C. Mibler Inc.-6415 Belair Rd.-21206			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1578	
F-654 70 1578		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Katherine Eva Fraunholz		2. DATE AND HOUR OF DEATH February 6, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines - Belair		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 833 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2620 E. Preston Street -21213	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 77 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Fraunholz		14. MOTHER'S MAIDEN NAME Eva W. Schmidt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-36-2678	
17. INFORMANT Frank W. Fraunholz-6611 Walther Blvd. Apt. D1		ADDRESS	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) arteriosclerotic cardio-vascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Upper respiratory virus infection		CAUSE OF DEATH arteriosclerotic cardio-vascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: senile degenerative arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Apr. 15 19 68 to Feb. 5 19 70 , that (I) (we) last saw the deceased alive on Feb. 5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE Ronald V. Goo 14.12 DEGREE		23B. DATE SIGNED 2/6/70	
23C. PHYSICIAN'S NAME (Type) Ronald V. Goo, M.D.		23D. ADDRESS 5500 Bryn Mawr Rd. Baltimore, Md. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 2-9-70	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206	

Estimated value of
inventory items
Inventory items

App. 1971

1971 12 31
1971 12 31

21/1/72
21/1/72
21/1/72

21/1/72
21/1/72

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

925.9

5/5

94, 93, 92, 91

90, 89, 88, 87

D-620

70 1580

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1580

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN D. DERRICK ^{Derrick}		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 2 5 70 4:35 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour February 5, 1970 4:35 p.m.	
6. SEX ^M White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE ^W Male		C. CITY OR TOWN ^{Balto} Hanover	
9. DATE OF BIRTH Aug. 15, 1956		10. AGE (In years last birthday) 13	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. none	
15. MOTHER'S MAIDEN NAME Dorothy Monroe (Dec)		18. INFORMANT Enoch Derrick	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Box 539 Ohio Ave. A. A. County		22F. HOW DID INJURY OCCUR? Self inflicted gunshot wound	
22D. TIME (Month) (Day) (Year) OF INJURY (APPROX.) 2 5 70		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/6/70	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 2/9/70	
24C. NAME OF CEMETERY or CREMATORY St. Johns Cem.		24D. LOCATION (City, town, or county) (State) Ellicott City Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Sabey, Jr.	
25C. FUNERAL DIRECTOR Higinbotham Slack		ADDRESS Ellicott City, Md. 21043	

Adrian Scott Jr.
Hawesville, Ky.

ACADEMY BOND

PAID IN FULL

ADRIAN SCOTT JR.

1950

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FUNERAL DIRECTOR: IMPORTANT

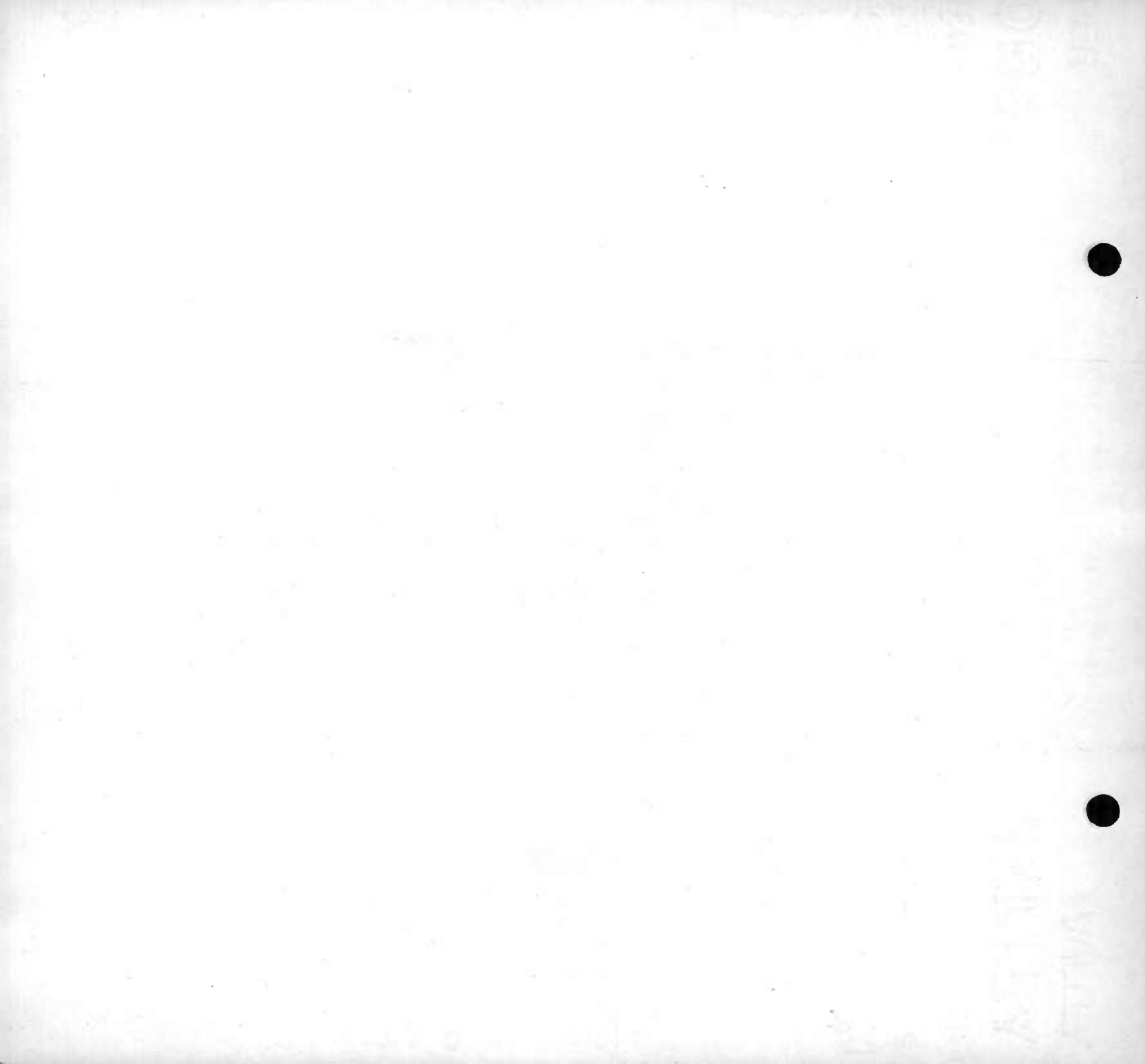
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-500		70 1581		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 1581	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) HENRY HEINE				2. DATE AND HOUR OF DEATH 2/4/70 7:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore				5. CITY OR TOWN HONKTON D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL Hospital				E. STREET AND NUMBER 5300					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/19/95		9. AGE (in years last birthday) 75		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY D.C. Government		11. BIRTHPLACE (State or foreign country) Dist. of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. S.	
13. FATHER'S NAME FREDERICK William HEINE				14. MOTHER'S MAIDEN NAME EMMA S. SIMPERS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO.		17. INFORMANT wife		ADDRESS SAME	
18. 1950 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Generalized Carcinomatosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Base bowel obstruction				CAUSE OF DEATH Intraabdominal (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Base bowel obstruction DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/24 19 70 to 2/4 19 70 that (I) (we) last saw the deceased alive on 2/4 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE H. J. Fossi				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2/4/70			
23C. PHYSICIAN'S NAME (Type) CARLOS FOSSI				23D. ADDRESS UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/9/70		24C. NAME of CEMETERY or CREMATORY Glenwood Cemetery		24D. LOCATION (City, town, or county) (State) Washington D.C.			
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970				25B. NAME OF REGISTRAR Robert E. Gawler, Jr.		25C. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.			
						5130 WISC. AVE., N. W. WASH., D. C. 20016			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-520 70 1582		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 1582	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>GEORGE HINES</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <u>2-5-70</u> <u>1:50 A.M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing Center</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1213 Light St.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> 8. COUNTY <u>Harford Co.</u>		C. CITY OR TOWN <u>Joppa</u>	
5. SEX <u>M</u> 6. RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <u>9-29-04</u>		9. AGE (In years last birthday) <u>65</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT WATCHMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SAND + GRAVEL</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN B. HINES</u>				14. MOTHER'S MAIDEN NAME <u>LAURA ABBOTT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>218-074574</u>		17. INFORMANT <u>MRS. SARAH CRESSWELL</u>		ADDRESS <u>HAURE DE GRACE, MD 207 ALLIANCE STREET</u>	
18. <u>200.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>LYMPHOMA</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>PETITULUM CELL SARCOMA</u> DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) _____			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> 19 <u>70</u> to <u>2-5</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>2-5</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Adoracion B. Paulino</u>				23B. DATE SIGNED <u>2-6-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Adoracion B. Paulino</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>2/8/1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>NORTH EAST METHODIST CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>NORTH EAST, HARFORD MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Gable, M.D.</u>		25C. FUNERAL DIRECTOR <u>Genarito J. San, Harve de Grace, Maryland</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250		70 1583		BALTIMORE CITY HEALTH DEPARTMENT		X 70 1583	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARY ELLEN JACKSON				2. DATE AND HOUR OF DEATH 2-8-70 8:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION U.S. PUBLIC HEALTH SERVICE HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY CARROLL	
C. CITY OR TOWN WESTMINSTER		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 54 WEBSTER ST.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-21-09	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME BUSH BROWN			
14. MOTHER'S MAIDEN NAME MARY ALDRIDGE				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 215-16-7948				17. INFORMANT HOSPITAL CHART			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE RESPIRATORY FAILURE				2 DAYS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BILATERAL BRONCHOPNEUMONIA				6 DAYS			
(C) DIFFUSE BRONCHIECTASIS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-3-69 to 2-8-70 that (I) (we) last saw the deceased alive on 2-8-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Irving D. Wolfe, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 2-9-70	
23C. PHYSICIAN'S NAME (Type) IRVING D. WOLFE, M.D.		23D. ADDRESS U.S. PUBLIC HEALTH SERVICE HOSPITAL 3100 WYMAN PK. DR. BALTO. MD. 21211					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/11/70		24C. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Garden		24D. LOCATION (City, town, or county) (State) Frederick, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR J. E. ...		ADDRESS Westminster, Md.	



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Melvin Marshall		Known <input checked="" type="checkbox"/> Month Day Year Hour		Estimated <input type="checkbox"/> Month Day Year Hour		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
40 St. Agnes Hospital		Baltimore		2 7 70 6:53 PM		Maryland Baltimore, CO. 5300			
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years last birthday)	
male		white		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		6/16/14		55	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
Md.		U.S.A.		unknown		machinist		unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
yes W.W.II				Mr. Charles Marshall		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
						(A) IMMEDIATE CAUSE			
						Multiple injuries			
						DUE TO, OR AS A CONSEQUENCE OF:			
						(B)			
						DUE TO, OR AS A CONSEQUENCE OF:			
						(C)			
						OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)					
2				yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED	
		street		Hammonds Ferry Rd. near 2nd Ave.		2 7 70 6:41 PM		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.							
pedestrian struck by car									
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy Chief Medical Examiner		DATE SIGNED 2/8/70			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		2/11/70		Glen Haven Cem.		Glen Burnie Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
FEB 10 1970		John J. Brown		John J. Brown & Son Inc.		St. Johns St.			

1881

IN

AMERICAN CENTRAL BANK

1881

ACADEMY

VALLEY

CLUB

1881

1881

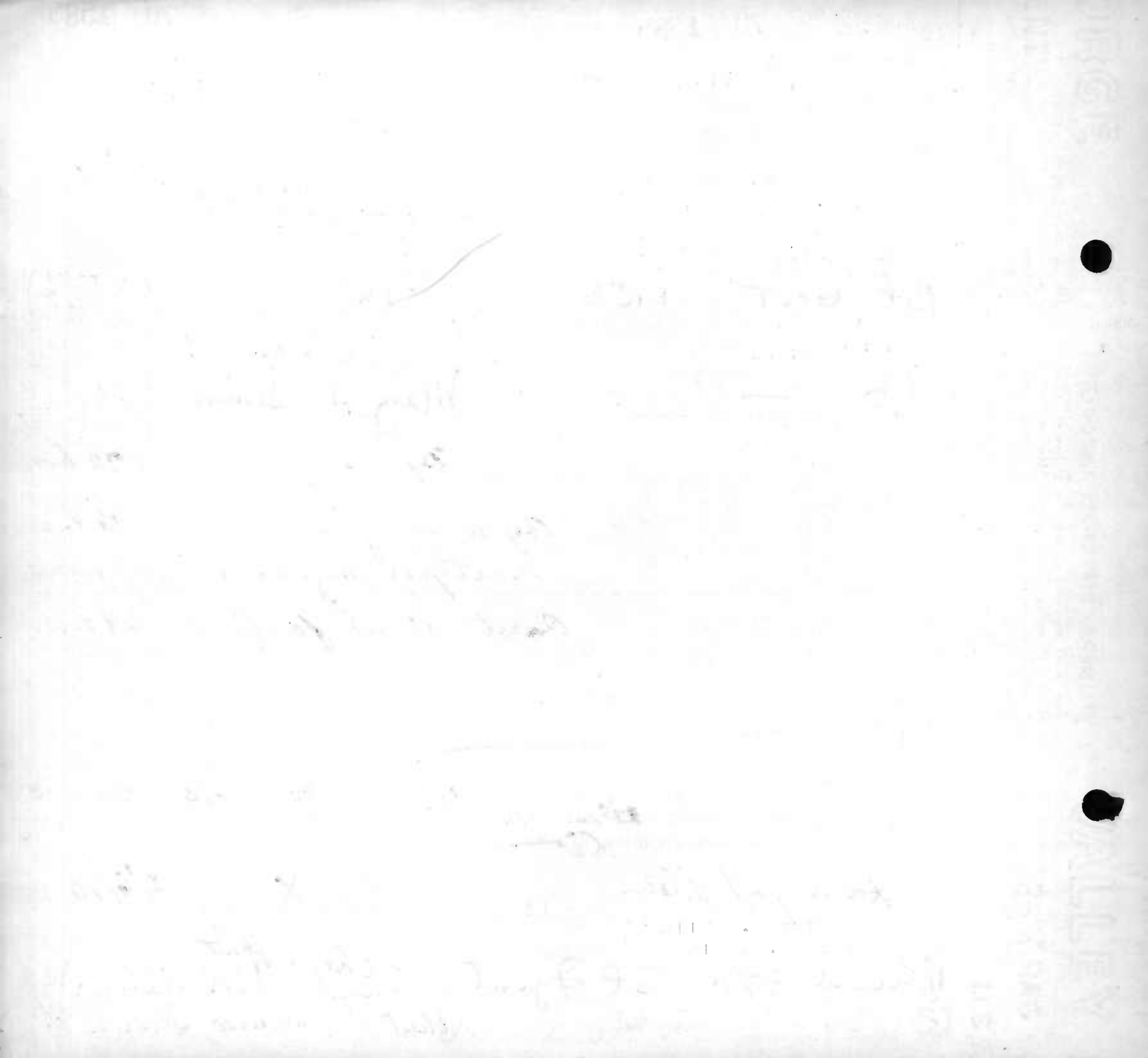
1881

1881

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-520 70 1585		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 1585	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) M. SIMMS, AUSTIN		2. DATE AND HOUR OF DEATH 02/06/70 2:45PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY AA CO.		5. SEX MALE 6. RACE WHITE	
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY, BALTO MD		C. CITY OR TOWN ARNOLD		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER BOX 703 RIDGEWAY AVE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07 30 02	
9. AGE (In years lost birthday) 67		10. KIND OF BUSINESS OR INDUSTRY IRS		11. BIRTHPLACE (State or foreign country) md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HARRY SIMMS		14. MOTHER'S MAIDEN NAME ? Clara ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 44 5072		17. INFORMANT Mary A. Simms - Above	
18. 205X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) SEPSIS		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEPSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) AGRAULOCYTOSIS DUE TO, OR AS A CONSEQUENCE OF		96 hrs.	
		(C) MULTIPLE MYELOMA		8 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Acute renal failure				24 hrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/27 1970 to 2/6 2:45pm 1970 , that (I) (we) last saw the deceased alive on 2:45pm 2/6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE Harvey G. Klein		23B. DATE SIGNED 2/6/70		23C. PHYSICIAN'S NAME (Type) HARVEY G. KLEIN	
23D. ADDRESS JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 2/9/70		24C. NAME OF CEMETERY OR CREMATORY St Ignace Cemetery		24D. LOCATION (City, town, or county) (State) Chapel Bel Air, Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert S. Lawrence		25C. FUNERAL DIRECTOR Severna Park	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-163 70 1586				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1586	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				JESSIE RUTH WEIFORD		5 Feb. 1970 9:00 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland Anne Arundel 52-00			
43 South Balto. Hospital				C. CITY OR TOWN Balto.#25 D. INSIDE CITY LIMITS? Brooklyn Park YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				622 Reyatta Ave. Balto. 25			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Female	White		28 Sept. 1923	46			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Labor Grade #3			Westinghouse		Baltimore, Maryland		
12. CITIZEN OF WHAT COUNTRY?			U.S.A.				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George H. Gore				Bessie Mayes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT (daughter) ADDRESS	
no -----				214 24 9627		Mrs. Norma J. Rutz -Govner Island, N/Y	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH CORONARY THROMBOSIS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
410.9 I				IMMEDIATE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				VIRUS URT + BRONCHITIS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 19 58 to 2-6 19 70, that (I) (we) last saw the deceased alive on 2-4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leon C. Perry, M.D.				23B. DATE SIGNED 2-6-70			
23C. PHYSICIAN'S NAME (Type) LEON C. PERRY, M.D.				23D. ADDRESS 325 HOSPITAL DRIVE GLEN BURNIE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial				Glen Haven Memorial Pk.		Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
FEB 10 1970		Robert E. Bailey, M.D.		Singleton Funeral Home		Glen Burnie, Md.	

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-260 70 1587		BALTIMORE CITY HEALTH DEPARTMENT		70 1587	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) WILLIAM J. FISHER			2. DATE AND HOUR OF DEATH 02-06-70 3:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY U.S.A. C. CITY OR TOWN BEL AIR D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 206 HIGHLAND ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-24-86	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer		10B. KIND OF BUSINESS OR INDUSTRY lightening Rods		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS FISHER		14. MOTHER'S MAIDEN NAME RACHEL BENNINGTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 185-28-4541		17. INFORMANT MRS ORA L. FISHER ADDRESS SAME AS ABOVE	
18. 422.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) RESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGESTIVE HEART FAILURE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 02-04 19 70 to 02-06 19 70 that (I) (we) last saw the deceased alive on 02-04 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Yamasaki M.D. DEGREE		23B. DATE SIGNED 02-06-70		23C. PHYSICIAN'S NAME (Type) YASUMASA YAMASAKI M.D. DEGREE	
23D. ADDRESS 33RD AND CALVERT STS BALTO. MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE Feb 9 1970		24C. NAME of CEMETERY or CREMATORY Slate Ridge Cemetery	
24D. LOCATION (City, town, or county) Delta		24E. LOCATION (City, town, or county) Yorta Co. Pa.			
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Dee E. Fisher		25C. FUNERAL DIRECTOR 056843 Harkins ADDRESS Delta, Pa.	

1924-25-26 83

WALL WHITE

MARKLAND

RACHEL BEAMER

HEAC FISHER

MRS. C. L. FISHER

WALL

REPAIRS

1924-25-26 83

1924-25-26 83

WALL

MARKLAND M.D. BEAMER

H-156

70 1588

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 1588

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Frederick John F. Hoffmeyer Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF DECEASED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3-13-70 35 Church Home and Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 2 6 70 8:05 p.m.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 702	
9. DATE OF BIRTH 7/14/13		10. AGE (In years last birthday) 56 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Hoffmeyer		14. STREET AND NUMBER 916 N. Milton Ave.	
15. MOTHER'S MAIDEN NAME Elizabeth Budder		16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sun Papers	
17. KIND OF BUSINESS OR INDUSTRY self-employed		18. SOCIAL SECURITY NO. 218-10-6344	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 2		20. INFORMANT ADDRESS Josephine Schaaf Hoffmeyer, wife, above	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E988X I CAUSE OF DEATH (A) IMMEDIATE CAUSE Craniocerebral injury DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) alley		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? rear of 900 Blk. Milton Ave.	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 2 2 70 ? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22F. HOW DID INJURY OCCUR? Possibly fell striking head	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/7/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/10/70	
24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2221 2601 E. Madison St.			

Letter from M.C. office 3-13-70
M.H.

ACADEMY BOND

FOR CONTENT

VALLEY PARK, LA

U.S.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-630 70 1589		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1589	
BIRTH NO.		1. NAME OF DECEASED <u>Thomas JOHN T. WARD</u>		2. DATE AND HOUR OF DEATH <u>2/6/70 11 pm</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		M. <u>2633</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD.</u>		B. COUNTY	
<u>UNION MEMORIAL HOSPITAL</u>		C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>3rd Street Balto Md</u>		E. STREET AND NUMBER <u>3415 Kenyon Avenue</u>			
5. SEX <u>male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/01/94</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Retired Cross Watchman</u>		<u>Pa. R.R. Unknown</u>		<u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Mr Frank WARD</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>717-07-6795</u>		17. INFORMANT <u>Wife Bessie (nee Krueger) wife above</u>	
18. <u>410.9 I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<u>Acute Myocardial Infarction</u>	
[This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.]		(B) <u>Rupture And Hemopericardium</u>		(C) <u>A.S.C.V.D</u>	
ANTECEDENT CAUSES		(C) <u>A.S.C.V.D</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(CS.)	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> 19 <u>70</u> to <u>2/6</u> 19 <u>70</u>		that (I) (we) last saw the deceased alive on <u>2/6</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (have) view the body after death.			
23A. SIGNATURE <u>DP van Kamen</u>		23B. DATE SIGNED <u>2/6/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>DP. VAN KAMEN MD</u>		23D. ADDRESS <u>Union Memorial Hospital 3rd Street BALTO</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/10/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		24F. NAME OF REGISTRAR <u>Robert F. ...</u>	
24G. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>		24H. ADDRESS <u>3333 Brehms Lane</u>			

Arctic Mammals
C. K. Johnson and H. M. Johnson
H. M. Johnson

(2)

for

N-550

70 1590

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 1590

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Edward WILLIAM NOONAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 2 5 70 12:50 R.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year February 5, 1970 12:50 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 2/27/14		10. AGE (in years last birthday) 55	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		14B. KIND OF BUSINESS OR INDUSTRY none	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Edward M. Noonan, brother, above		ADDRESS	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20A. DATE OF OPERATION 0 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) No 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR? 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/6/70 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 2/9/70 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970 25B. NAME OF REGISTRAR 77080506 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1591	
M-215 70 1591		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES J. MAKIBBIN Sr.		2. DATE AND HOUR OF DEATH 2/4/70 6:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md., B. COUNTY 2642			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4229 Stanwood Ave.,			
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1924	9. AGE (in years last birthday) 45	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Foreman		10B. KIND OF BUSINESS OR INDUSTRY B & O R. R.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Paul Makibbin		14. MOTHER'S MAIDEN NAME Anna Henely	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 2- Navy 21		16. SOCIAL SECURITY NO. 17-12-9730		17. INFORMANT ADDRESS James J. Makibbin, Jr., son, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I 162-1		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest < 1 hr.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(B) DUE TO, OR AS A CONSEQUENCE OF: Aspiration gastric contents < 1 hr.			
(C) Specimen cell Ca @ lung.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2/3/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Specimen cell Ca lung.		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/2 19 70 to 2/4 19 70 that (I) (we) last saw the deceased alive on 2/4 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Karl F. Meach, Jr. M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) KARL F. MEACH, Jr. M.D.	
23D. ADDRESS		23E. NAME of REGISTRAR Robert E. ...		23F. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/9/70		24C. NAME of CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. FEB 10 1970		24F. ADDRESS 38310 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-655		70 1592		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1592	
1. NAME OF DECEASED (Type or Print) MARY A. BURNHAM				2. DATE AND HOUR OF DEATH FEB 8, 1970 3:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5705 W. LINNEN AVE.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/95	9. AGE (in years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker Rag
11. BIRTHPLACE (State or foreign country) Ireland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Michael Creaghan				14. MOTHER'S MAIDEN NAME Sarah Josephine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219 16 8019		17. INFORMANT James C Burnham ADDRESS 24209 1304 Ashbury Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.40 250.9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Emboli (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD - CHF (C) Chronic Atrial Fibrillation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 21 1970 to FEB 8 1970 that (I) (we) last saw the deceased alive on FEB 8 1970 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Victor Borden M.D.				23B. DATE SIGNED FEB-8, 1970		23C. PHYSICIAN'S NAME (Type) VICTOR BORDEN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2-11-70		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cem		24D. LOCATION (City, town, or county) (State) Pikesville Balt Co Md	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Budget Funeral Home		ADDRESS Baltimore	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-623		70 1593		BALTIMORE CITY HEALTH DEPARTMENT		70 1593	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Crist, Lucinda C.</u>				2. DATE AND HOUR OF DEATH <u>February 7, 1970</u> <u>10.15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>1348</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1312 W. 40TH STREET</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01-06-88</u>	9. AGE (In years last birthday) <u>82</u>	10. Under 1 Mo.	11. Under 1 Yr.	12. Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>GEORGE CHIRTON</u>				14. MOTHER'S MAIDEN NAME <u>SALTZGIVER, LIVINGE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>184-16-7319</u>		17. INFORMANT <u>AGNES KNAPP</u>		ADDRESS <u>1312 W 40TH ST.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>431.9 + 154.1</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>- Thyrotoxicosis</u> <u>- Rectal CARCINOMA - 1934 (REMOVED)</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 7</u> 19 <u>70</u> to <u>FEBRUARY 7</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>FEBRUARY 7</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Miguel Karacuschansky M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>FEBRUARY 7, 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>Miguel KARACUSCHANSKY M.D.</u>				23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>2/11/70</u>		24C. NAME of CEMETERY or CREMATORY <u>CALVERY CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>ALTOONA PENNA.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Briggs Funeral Home</u>		ADDRESS <u>3631 FALLS</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 1594</u>	
BIRTH NO. <u>L-522</u>		70 1594 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>William WILBUR LANCASTER</u>		2. DATE AND HOUR OF DEATH <u>2/5/70</u> <u>3 25</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>702</u>	
		C. CITY OR TOWN <u>BALTIMORE</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>530 N. GLOVER ST.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 05</u>
		9. AGE (In years last birthday) <u>64</u>	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Smelting Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Joseph Lancaster</u>		14. MOTHER'S MAIDEN NAME <u>Roberta -</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216105481</u>	17. INFORMANT <u>Sarah R Lancaster</u>
18. ADDRESS <u>Same</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>WIDESPREAD CARCINOMA OF LUNG</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> 19 <u>70</u> to <u>2/5</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/5</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>2/5/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL J. PREECE MD.</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSP.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>	24B. DATE <u>2-9-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Men Bk Bldg Md</u>	24D. LOCATION (City, town, or county) (State) <u>21234</u>
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>	25B. NAME OF REGISTRAR <u>[Signature]</u>	25C. FUNERAL DIRECTOR <u>Burial Funeral Home Bk Bldg Md</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1595	
F-460		70 1595		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		70 1595		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FOWLER, Charles G		February 6, 1970		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
Veterans Administration Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. SEX	
3900 Loch Raven Boulevard		A. STATE Maryland		Male	
Baltimore, Maryland		B. COUNTY		White	
23		C. CITY OR TOWN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
		Baltimore		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
		D. INSIDE CITY LIMITS?		8. DATE OF BIRTH	
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5/30/10	
		E. STREET AND NUMBER		9. AGE (In years last birthday)	
		820 Washington Boulevard		59	
				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
				Railroad man	
				11. BIRTHPLACE (State or foreign country)	
				Clifton Forge, Va.	
				12. CITIZEN OF WHAT COUNTRY?	
				USA	
				13. FATHER'S NAME	
				Ralph Fowler	
				14. MOTHER'S MAIDEN NAME	
				Constance	
				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
				Yes 12/8/42 - 11/2/43	
				16. SOCIAL SECURITY NO.	
				705-10-6449	
				17. INFORMANT	
				VA Hospital Records	
				ADDRESS	
				3900 Loch Raven Boulevard, Balto., Md 21218	
				18. CAUSE OF DEATH	
				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
				(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				Pulmonary Edema	
				1 Week	
				(B) CVA	
				DUE TO, OR AS A CONSEQUENCE OF:	
				1 Week	
				(C)	
				II	
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
				19A. DATE OF OPERATION	
				1-19-70	
				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
				Femoral Hernioraphy	
				20A. AUTOPSY? (Yes or No)	
				Yes	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes	
				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				21D. TIME OF INJURY (APPROX.)	
				21E. INJURY OCCURRED	
				21F. HOW DID INJURY OCCUR?	
				22. I certify that (he) (this hospital) attended the deceased from January 19th 1970 to February 6th 1970	
				that (he) (we) last saw the deceased alive on February 6th 1970 and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.	
				23A. SIGNATURE	
				23B. DATE SIGNED	
				2-7-70	
				23C. PHYSICIAN'S NAME (Type)	
				23D. ADDRESS	
				3900 Loch Raven Boulevard	
				Baltimore, Maryland 21218	
				24A. BURIAL CREMATION, REMOVAL (Specify)	
				24B. DATE	
				24C. NAME of CEMETERY or CREMATORY	
				24D. LOCATION (City, town, or county) (State)	
				Burial	
				2/9/70	
				Loudon Park Cemetery	
				Baltimore, Maryland	
				25A. DATE REC'D BY HEALTH DEPT.	
				25B. NAME OF REGISTRAR	
				25C. FUNERAL DIRECTOR	
				ADDRESS	
				FEB 10 1970	
				John B. Morden, Inc. 3000 E. Baltimore St.	



MACKALL, John
1319390

FUNERAL DIRECTOR: IMPORTANT

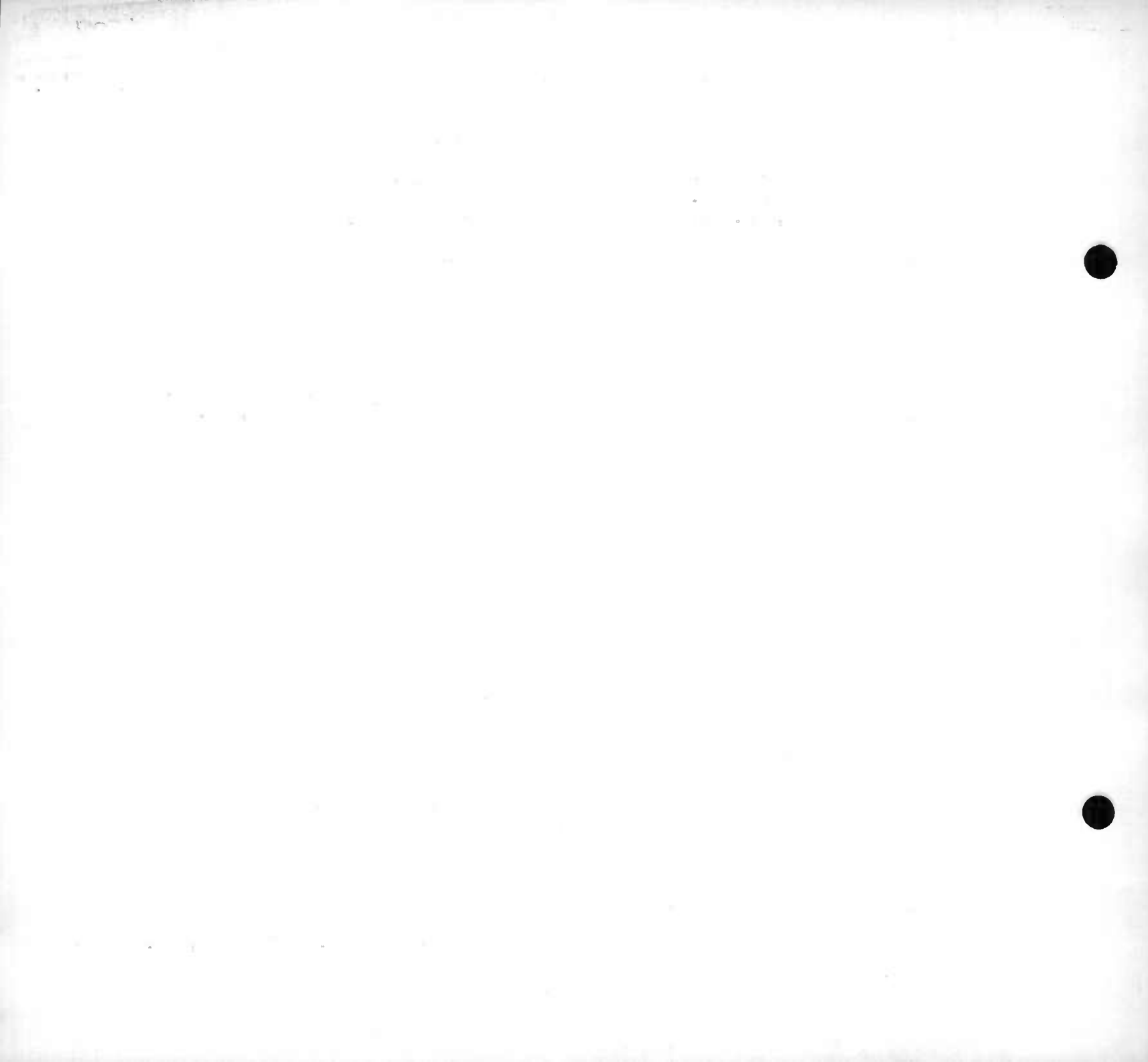
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-240 70 1596		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 1596	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN MACKALL		FEB 5, 70 10:50 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY CALVERT	
THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN HUNTINGTOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER					
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11, 10	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME COLUMBUS MACKALL		14. MOTHER'S MAIDEN NAME LIZZIE GROSE		12. CITIZEN OF WHAT COUNTRY? USA..	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-9833		17. INFORMANT Josethel Mackall Huntingtown, Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular collapse (B) DUE TO, OR AS A CONSEQUENCE OF: Metastatic ca (C) DUE TO, OR AS A CONSEQUENCE OF: Ca of Pancreas		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10:50 A 6 mo ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2/4/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EG obstruction		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 2-3 1970 to 2-5 1970 that (I) (we) lost saw the deceased alive on 2-5 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. J. Fee MD		23B. DATE SIGNED 2-5-70			
23C. PHYSICIAN'S NAME (Type) H. J. Fee MD		23D. ADDRESS Johns Hopk Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2-10-70		24C. NAME OF CEMETERY OR CREMATORY St. Edmond Ch Cem.	
				24D. LOCATION (City, town, or county) (State) Sunderland Calvert Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Anthony Z. Sewell	
				ADDRESS Prince Fred. Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400		70 1597		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1597	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Gertrute Bell (Gertrude)				2. DATE AND HOUR OF DEATH 2-7-70 6:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 402			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female				6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8-10-99				9. AGE (In years last birthday) 70		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Willie Perry			
14. MOTHER'S MAIDEN NAME Ellen				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT BCH Records: 4940 Eastern Ave. Baltimore, Md. 21224 ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 182.041 250.9 ADENOCARCINOMA OF ENDOMETRIUM 1598				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DIABETE MELLITUS			
MEDICAL CERTIFICATION		19A. DATE OF OPERATION 1-30-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PELVIC NALIG NANCY		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-22-1970 to 2-7-1970 that (I) (we) last saw the deceased alive on 2-7-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Whoburn L S. Kito				23B. DATE SIGNED 2-7-70		23C. PHYSICIAN'S NAME (Typo) L S. Kito	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 2/14/70		24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery	
24D. LOCATION Baltimore Md				24E. DATE REC'D BY HEALTH DEPT. FEB 10 1970		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR Halstead				24H. ADDRESS 1206 W North Ave		24I. DATE FEB 10 1970	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

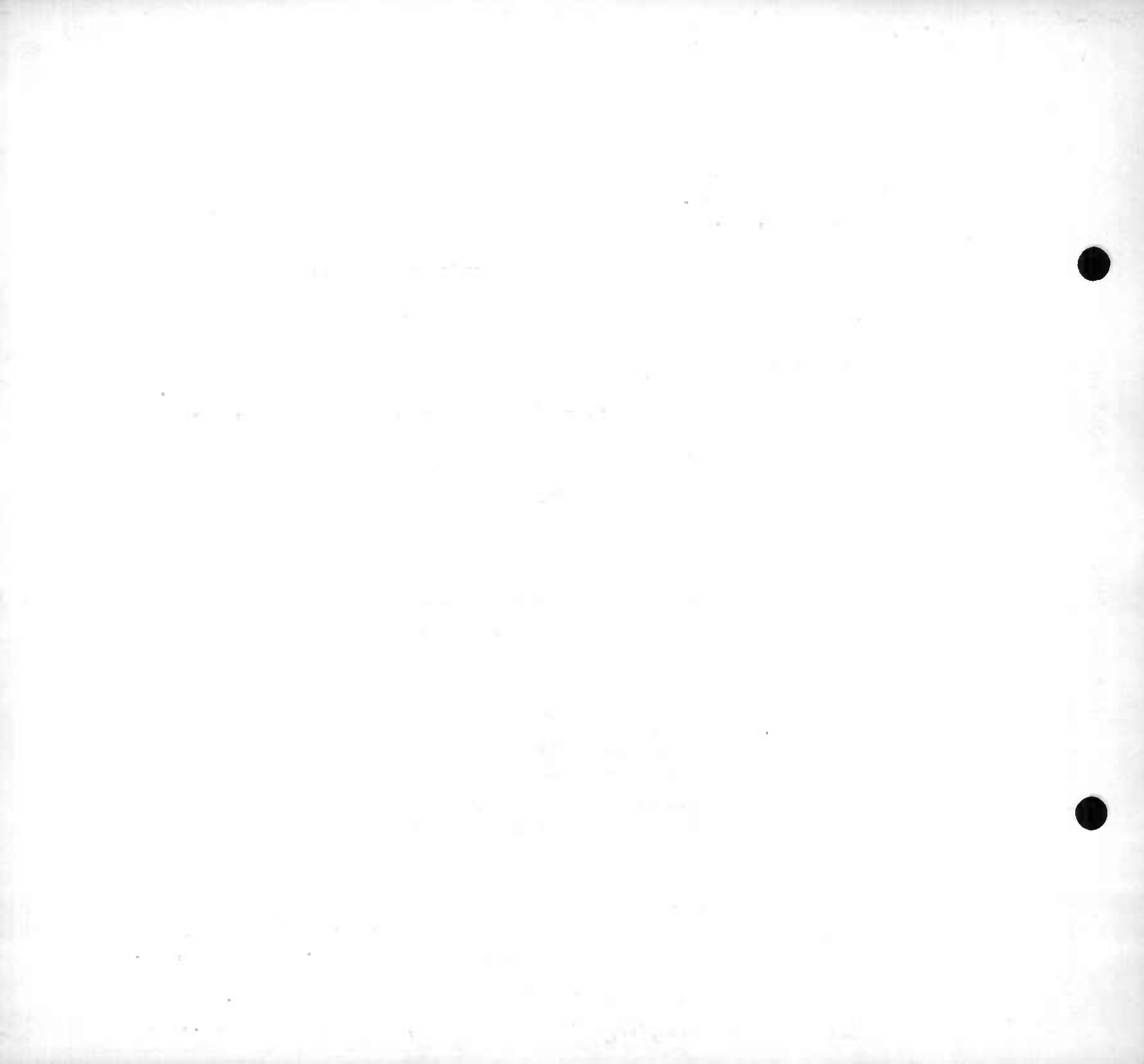
BIRTH NO. <u>H-436</u> <u>70</u> <u>1598</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70</u> <u>1598</u>	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>Holder, Pearl</u>				2. DATE AND HOUR OF DEATH <u>2-6-70</u> <u>5:25</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1402</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital</u> <u>1514 Divison Street 21217</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1411 McCulloh Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-11</u>	9. AOE (in years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Henry Price</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Brown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Howard Drumond</u>		ADDRESS <u>Same</u>
18. <u>250.9 + 1009.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>multiple pulmonary embolism</u> <u>Anteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Gastroenteritis</u> <u>Diabetes Mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? <input checked="" type="checkbox"/> (Yes) or No <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-31-69</u> <u>19</u> to <u>2-6-70</u> <u>19</u> that (I) (we) last saw the deceased alive on <u>2-6-70</u> <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Raymundo R. Corpuz</u>				23B. DATE SIGNED <u>Feb. 6, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>Raymundo R. Corpuz</u>				23D. ADDRESS <u>1514 Divison Street Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>2/12/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>0 A D Halstead</u>		ADDRESS <u>1206 W north Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
14-620		70 1599		70 1599	
1. NAME OF DECEASED (Type or Print) <u>Eva Mac Harris</u>			2. DATE AND HOUR OF DEATH <u>2/7/70</u> <u>7:30 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2646</u>		
5. SEX <u>Female</u>			6. RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>6-25-93</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>William Chilcoat</u>			14. MOTHER'S MAIDEN NAME <u>Emma Parsons</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-22-7255</u>		
17. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
18. <u>4:10:0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Acute Inferior lateral MI</u> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6-8 hrs</u>			19. DATE OF OPERATION <u>2</u>		
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indify medical examiner			21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
22. I certify that (1) (this hospital) attended the deceased from <u>7 Feb</u> 19 <u>70</u> to <u>7 Feb</u> 19 <u>70</u> and that (1) (we) lost saw the deceased alive on <u>7 Feb</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.			23. DATE SIGNED <u>7 Feb 70</u>		
24. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			25. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		
26. DATE <u>2/11/70</u>			27. NAME OF REGISTRAR <u>Robert E. Taylor, Md.</u>		
28. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>			29. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Ave., 21228</u>		
29. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			30. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>		



F-326		70 1600		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		70 1600					
BIRTH NO.				REG. NO.									
1. NAME OF DECEASED (Type or Print) WILLIAM FITZGERALD				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month		Day		Year		Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 19 N. Calhoun St.				3. DATE PRONOUNCED DEAD		Month		Day		Year		Hour	
						2		8		70		4 P. M.	
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		10. CITY OR TOWN Balto.		11. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 7/ /08				10. AGE (In years last birthday) 61		11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.		12. STREET AND NUMBER 19 N. Calhoun St.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. KIND OF BUSINESS OR INDUSTRY none		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary C. Davis, 19 N. Calhoun St.				18. ADDRESS									
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).													
21. DATE OF OPERATION				22. CONDITION FOR WHICH OPERATION WAS PERFORMED		23. AUTOPSY? (Yes or No) no							
24. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.)		26. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?							
27. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		29. HOW DID INJURY OCCUR?							
30. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				31. ACTUAL SIGNATURE Russell S. Fisher, M.D.		32. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		33. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		34. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		35. DATE SIGNED 2-9-70	
36. BURIAL CREMATION, REMOVAL (Specify) Burial				37. DATE 2/10/70		38. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		39. LOCATION (City, town, or county) (State) Baltimore, Maryland		40. DATE REC'D BY HEALTH DEPT. FEB 10 1970		41. NAME OF REGISTRAR Robert E. Fisher	
42. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229				43. ADDRESS									

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

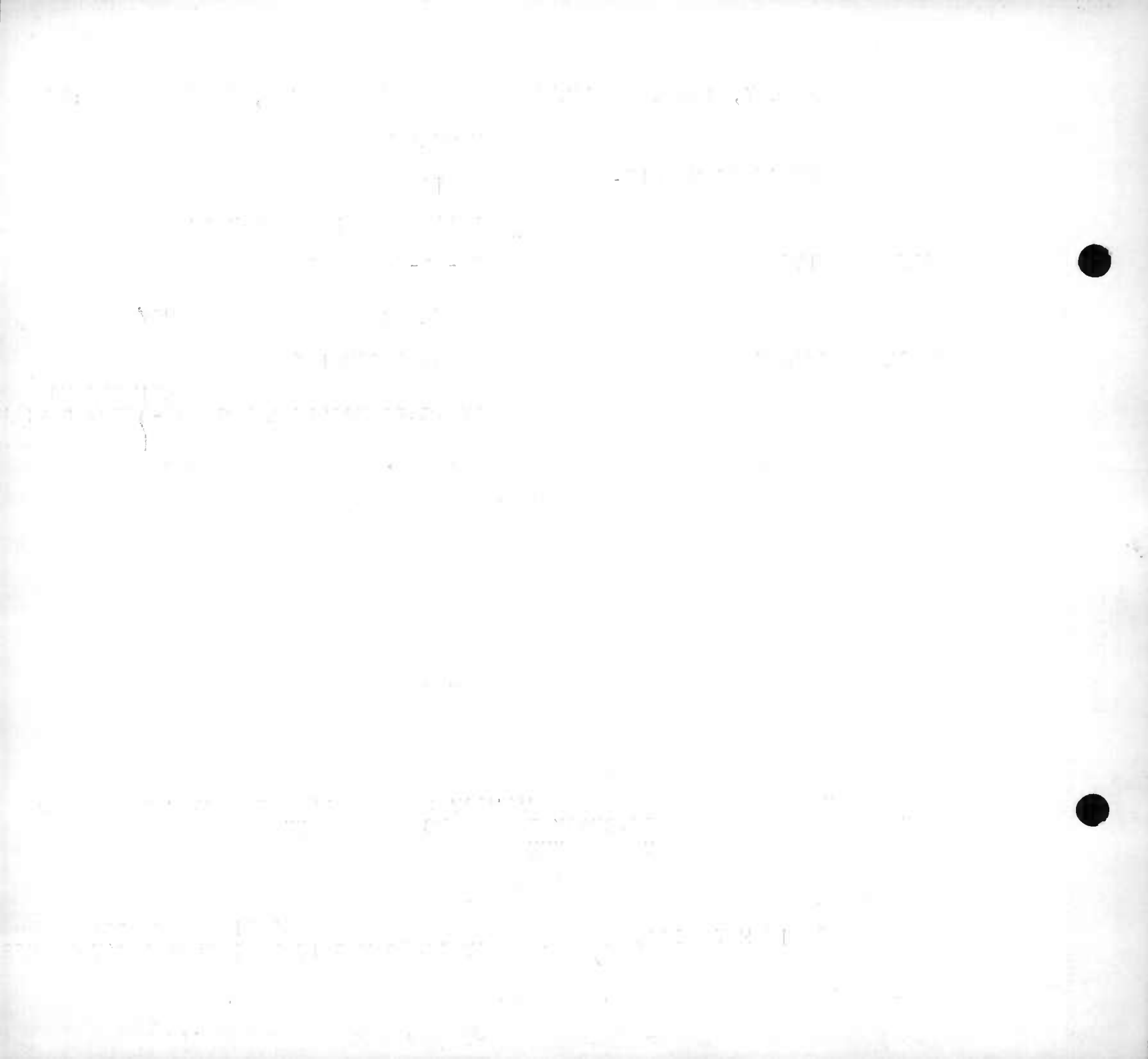
BALTIMORE CITY HEALTH DEPARTMENT				70 1601	
CERTIFICATE OF DEATH				REG. NO. 70 1601	
BIRTH NO. <u>R-400 70 1601</u>					
1. NAME OF DECEASED (Type or Print) <u>RILEY, HARVEY</u>			2. DATE AND HOUR OF DEATH <u>February 9, 1970 8:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>-</u>		
5. SEX <u>Male</u>			6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>July 17, 1903</u>			9. AGE (In years last birthday) <u>66</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY <u>United States</u>		
13. FATHER'S NAME <u>Jededdiah RILEY</u>			14. MOTHER'S MAIDEN NAME <u>Mary Clark</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>705-07-9287</u>		17. INFORMANT <u>Chart</u>
18. <u>323 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Ascending myelitis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> <u>few weeks</u> <u>1 m. abt.</u>
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>2-2-1970</u> to <u>2-9-1970</u> that <u>(X)</u> (we) lost saw the deceased alive on <u>2-9-1970</u> and that <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Abbas, M.D.</u>					23B. DATE SIGNED <u>2-9-70</u>
23C. PHYSICIAN'S NAME (Type) <u>M. Abbas, M.D.</u>			23D. ADDRESS <u>Bon Secours Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/12/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Witzke, 4101 Edmondson Ave., 21229</u>	



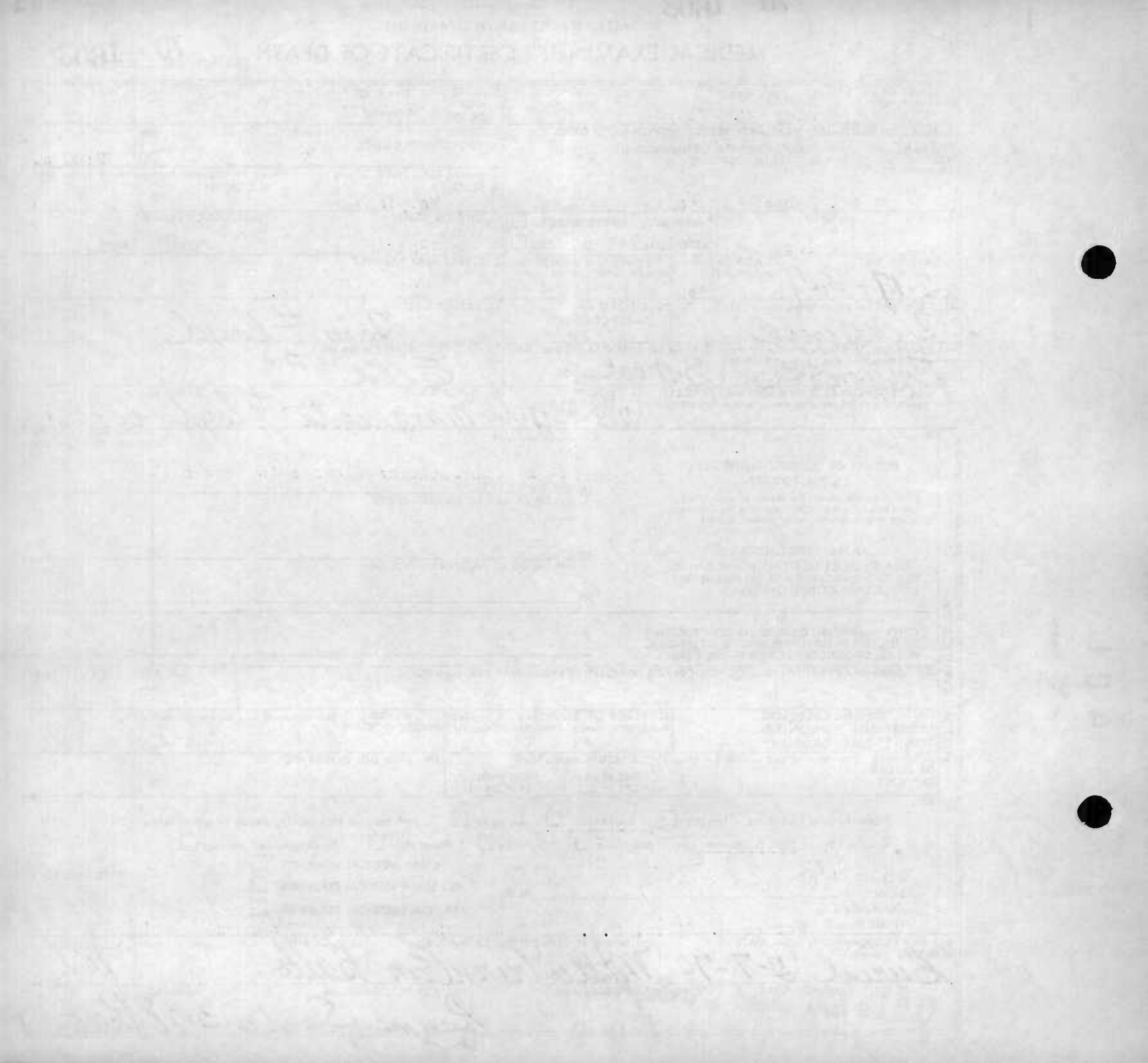
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 1602</u>	
BIRTH NO. <u>68-14653</u> <u>1602</u>		1. NAME OF DECEASED (Type or Print) <u>SEELEY, DONALD DOUGLAS</u>			
2. DATE AND HOUR OF DEATH <u>FEBRUARY 7, 1970</u> <u>6:15PM.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>ST AGNES HOSPITAL</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2735</u>			
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>3814 E NORTHERN PARKWAY</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <u>08-02-68</u> 9. AGE (In years last birthday) <u>1</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>DONALD C SEELEY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <u>BARBARA SCHMIDT</u>	
17. INFORMANT <u>BALTIMORE MD</u>		ADDRESS <u>ST AGNES HOSPITAL RECORDS-CATON & WILKINS</u>			
18. <u>751.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		1. <u>Congenital Tracheo esophageal fistula</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>& multiple repairs + breakdowns</u>			
		2. <u>Bruise lacer & meningitis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Unknown - less than 1 mo.</u>			
		3. (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Swallowed roasting 2nd to decubate rigidity</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>JANUARY 2</u> 19 <u>70</u> to <u>FEBRUARY 7</u> 19 <u>70</u> that (X) (we) last saw the deceased alive on <u>FEBRUARY 7</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edwin H T Besson MD</u>		23B. DATE SIGNED <u>2/8/70</u>		23C. PHYSICIAN'S NAME (Type) <u>EDWIN H T BESSON MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/11/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, MD</u>		25C. FUNERAL DIRECTOR <u>Witke, 24101 Edmondson Ave., 21229</u>	



BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 1603					
1. NAME OF DECEASED (Type or Print) George C. Floyd												2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital												3. DATE PRONOUNCED DEAD Month Day Year Hour 2 3 70 12:00 a.m.	
5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 908												C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male		7. RACE colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 2144 Aiken St.				13. FATHER'S NAME Tom Floyd			
9. DATE OF BIRTH 2-17-1909				10. AGE (In years last birthday) 60		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?		15. MOTHER'S MAIDEN NAME Ella P.			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				14B. KIND OF BUSINESS OR INDUSTRY School		17. SOCIAL SECURITY NO. 218-033460				18. INFORMANT ADDRESS Marguerita Floyd Wells			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				19. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtento, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:									
				(B) DUE TO, OR AS A CONSEQUENCE OF:									
				(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).													
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) NO					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner H. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 2/3/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 2-7-70				24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem Balto.					
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS Raymond Sanders 217 E. Preston St					



H-200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1604

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CATHERINE HOUSE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> February 5, 1970 8:25 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year February 5, 1970 8:25 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 5 - 1906		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY EVANS		14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2609	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 212 26 1850		18. INFORMANT Mr. Milton G. House - 3829 Sait Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac tamponade		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (b) Perforations of right ventricle DUE TO, OR AS A CONSEQUENCE OF: (c) Catheterization for pulmonary arteriogram			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2-5-70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Delineation of suspected pulmonary emboli	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? Johns Hopkins Hospital 604		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 2-5-70	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Incident to right heart catheterization for suspected pulmonary emboli	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/6/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-70	
24C. NAME OF CEMETERY or CREMATORY BALTIMORE Cem.		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Sabes, M.D.	
25C. FUNERAL DIRECTOR Hartley Miller - 2334 Jefferson St.		ADDRESS	

1
S-530

70 1605

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1605

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RUTH K. SMITH		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Feb. 4 1970		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3304 Virginia Avenue (DOA)		3. DATE PRONOUNCED DEAD Month Day Year February 4, 1970		Hour M. 7:20 A.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2716					
6. SEX Female	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-3-22 3-3-23		10. AGE (In years last birthday) 47		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 3304 Virginia Avenue	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Counter-Girl		14B. KIND OF BUSINESS OR INDUSTRY Goucher College		13. FATHER'S NAME Eugene James	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 219-20-6662		15. MOTHER'S MAIDEN NAME ?	
18. INFORMANT Mr. James L. Smith		ADDRESS 3304 Virginia Ave.			
19. 493 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fatty Metamorphosis of Liver		CAUSE OF DEATH Bronchial Asthma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes (Partial)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> (Partial) Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/4/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-70		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Nutter Funeral Home	
24D. LOCATION (City, town, or county) Baltimore,		24E. LOCATION (City, town, or county) Md		25D. ADDRESS 3035 W. North Avenue	

2/16/70 - Correction form from funeral director.

Bo.

ACADEMY OF MUSIC

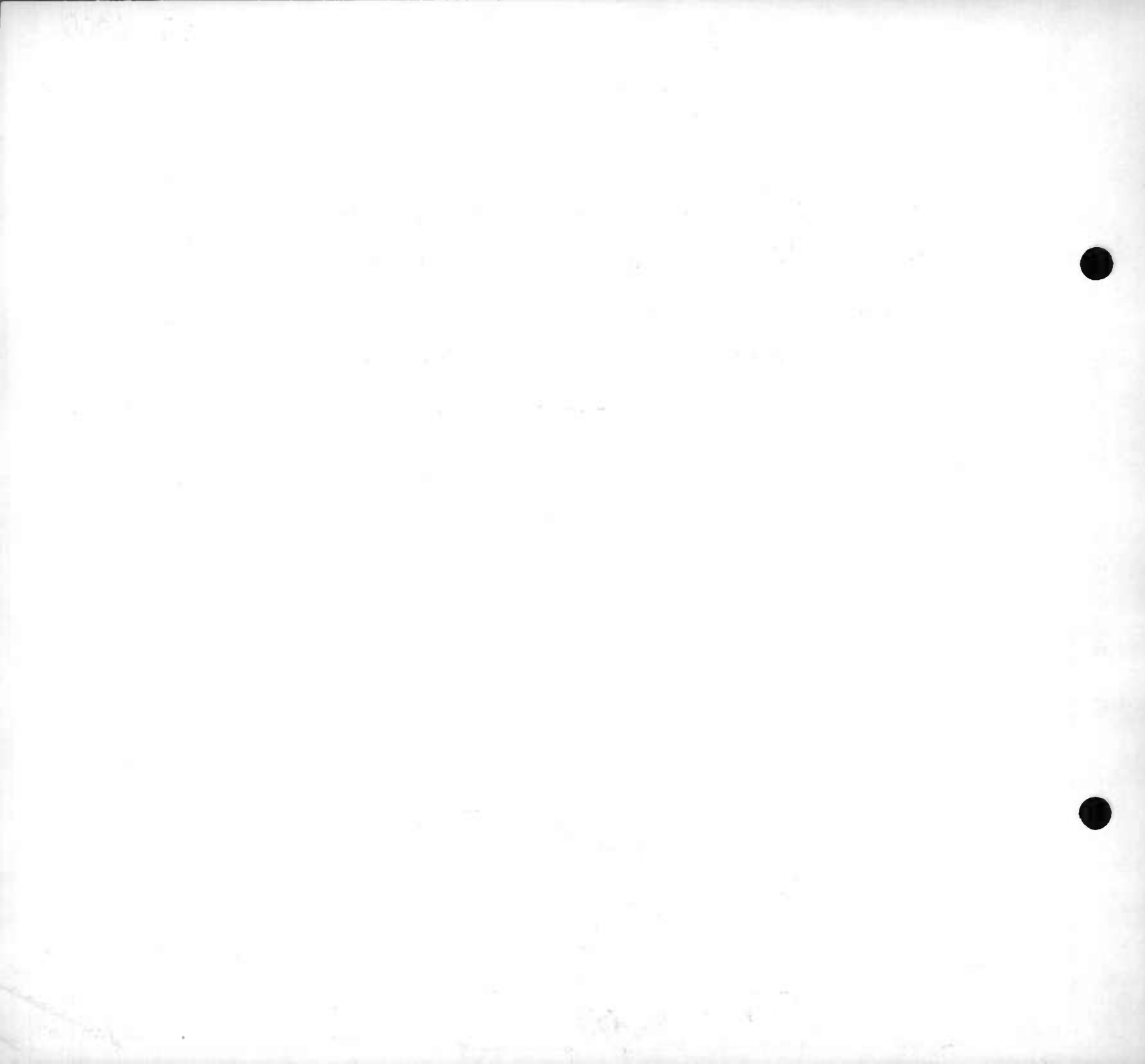
HAS COURTESY

VALLEY EXHIBITS CO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 1606		REG. NO. 70 1606	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Spicer, Peter</i>		2. DATE AND HOUR OF DEATH <i>2/7/70</i> <i>11 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Sinai Hospital of Balto.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1511</i>		
5. SEX <i>M</i>			6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Custodian</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Theater</i>		8. DATE OF BIRTH <i>7/19/00</i>	
13. FATHER'S NAME <i>Thomas Spicer</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Todd</i>		9. AGE (In years last birthday) <i>69</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>142-12-2854A</i>		17. INFORMANT ADDRESS <i>Mrs. Esther Chaney 3919 Cederdale Rd.</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Renal Chronic Insuff.</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Diabetes Mellitus</i> <i>Cardiac Heart Insufficiency</i> <i>Live Insufficiency</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/2</i> 19 <i>70</i> to <i>2/7</i> 19 <i>70</i> that (I) <i>(we)</i> last saw the deceased alive on <i>2/7</i> 19 <i>70</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>Perel M.D.</i>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>Carlos R. Perel</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>2-12-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cemetery</i>
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 10 1970</i>			25B. NAME OF REGISTRAR <i>Robert E. Taber, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Nutter Funeral Home 3035 W. North Avenue</i>
24D. LOCATION <i>Baltimore</i>			24E. LOCATION <i>Md</i>		



70 1607

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1607

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Holmes		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 2 Day 7 Year 70 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 120 N. Carlton St.		3. DATE PRONOUNCED DEAD Month 2 Day 7 Year 70 Hour 11:45 a.m.	
6. SEX male		7. RACE colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1-5-86		10. AGE (in years last birthday) 84	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Construction	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 217-09-5110	
18. INFORMANT Mr. Winston Hall		ADDRESS 2813 Windsor Avenue	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner DATE SIGNED 2/8/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-11-70	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) Baltimore Co., Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Nutter Funeral Home		ADDRESS 3035 W. North Ave.	

ALABAMA NEW BONDING

COMPANY

1111 11th Street

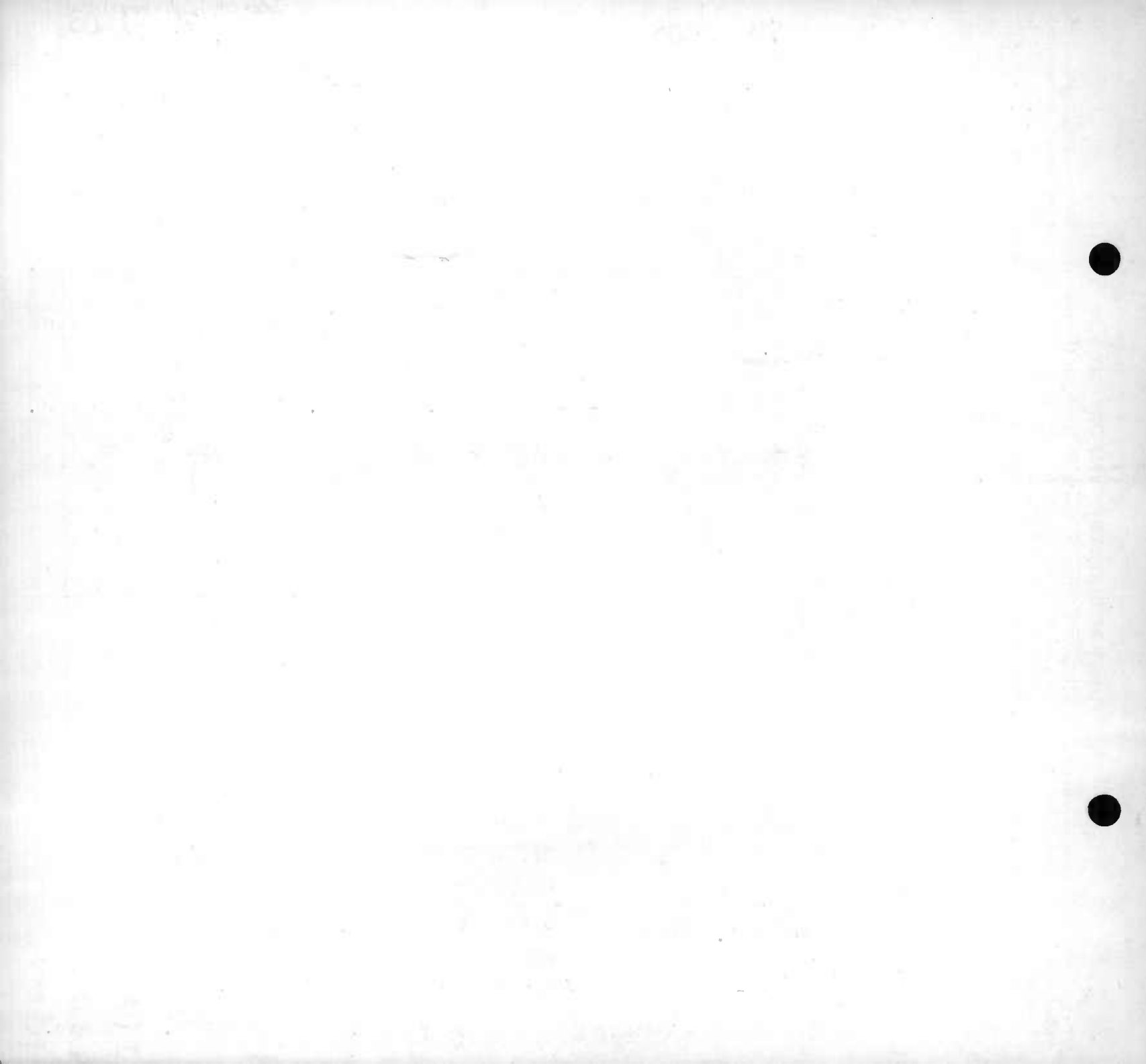
Mobile, AL

Handwritten signature and date

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1608	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Snowanna R. Singleton		2-4-70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 417 Laurens Street			Maryland		1402
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female			6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10-12-92		9. AGE (In years last birthday) 77		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME George W. Robinson		
14. MOTHER'S MAIDEN NAME Estelle Leggette			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 262-02-0017		17. INFORMANT ADDRESS Mrs. Georgia P. Mitchell 417 Laurens St.			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of ovary 2 metastases</i>					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 2 1970 to Feb 2 1970, that (I) (we) last saw the deceased alive on Feb 2 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Benigno R. Lazaro</i>				23B. DATE SIGNED 2-6-70	
23C. PHYSICIAN'S NAME (Type) Benigno R. Lazaro MD				23D. ADDRESS 1836 Edmondson Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-70		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore Co., Md		25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Nutter Funeral Home 3035 W. North Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1609
BIRTH NO. 70 1609		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) COOK, Clara T.		2. DATE AND HOUR OF DEATH February 8, 1970 5:15 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Bolton Hill Nursing & Convalescent Ctr.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1403		
FULL NAME OF HOSPITAL OR INSTITUTION 90 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-85 9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher-Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mass.
13. FATHER'S NAME Jefferson W. Thompson		14. MOTHER'S MAIDEN NAME Cecelia ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-9061		17. INFORMANT Mr. Robert A. Moore ADDRESS 652 Oglethorpe St., N.E. Wash., D.C. 20011
18. 4-12-3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Osteolytic lesions of femur (B) cerebral metastases (C) arteriosclerotic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months 11/69 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1/26 19 70 to 2/8 19 70 , that (I) (we) last saw the deceased alive on 2/8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE ae Martin		23B. DATE SIGNED 2/8/70		23C. PHYSICIAN'S NAME (Type) ae Martin
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-12-70		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State) Md		
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Nutter Funeral Home ADDRESS 3035 W. North Avenue

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BALTIMORE CITY HEALTH DEPARTMENT

70 1610

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1610

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JEROME CARTER		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> 2 8 70 12:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 700 W. Fayette St. (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 2 8 70 12:30 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 1/6/11		10. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Van Carter		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Nora Johnson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 578-18-0194		18. INFORMANT Mr. Harry Johnson 2120 Bolton Street	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-9-70 EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/11/70	
24C. NAME OF CEMETERY or CREMATORY Red Hill Cemetery		24D. LOCATION (City, town, or county) (State) Cliftonforge, Va.	
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Nutter Funeral Home		ADDRESS 3035 W. North Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1611
70 1611		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CLARENCE E. GRAY		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 2-6-70 8:30 a. M.		
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1502		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Male		E. STREET AND NUMBER 1717 N. FULTON AVENUE		
6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Worker		8. DATE OF BIRTH 11-3-94		
10B. KIND OF BUSINESS OR INDUSTRY Railroad		9. AGE (In years last birthday) 76		
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Samuel Gray		14. MOTHER'S MAIDEN NAME Alveta		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5 Aug 18 21 Feb 19		16. SOCIAL SECURITY NO. 717-57-7804		
17. INFORMANT Mrs. McCarroll Gray		ADDRESS 1717 N. Fulton Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Renal failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-31-70		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2-6-70		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from 1-31-70 to 2-6-70 , that (1) (we) last saw the deceased alive on 2-5-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE P. G. Nanes M.D.				23B. DATE SIGNED 2-6-70
23C. PHYSICIAN'S NAME (Type) P. G. Nanes M.D.		23D. ADDRESS Lutheran Hosp Ashburton St - Balto.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/10/70		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem Baltimore
24D. LOCATION (City, town, or county) Baltimore		(State) Md.		
25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Gray & Rose 2222 W. North Ave

General

...

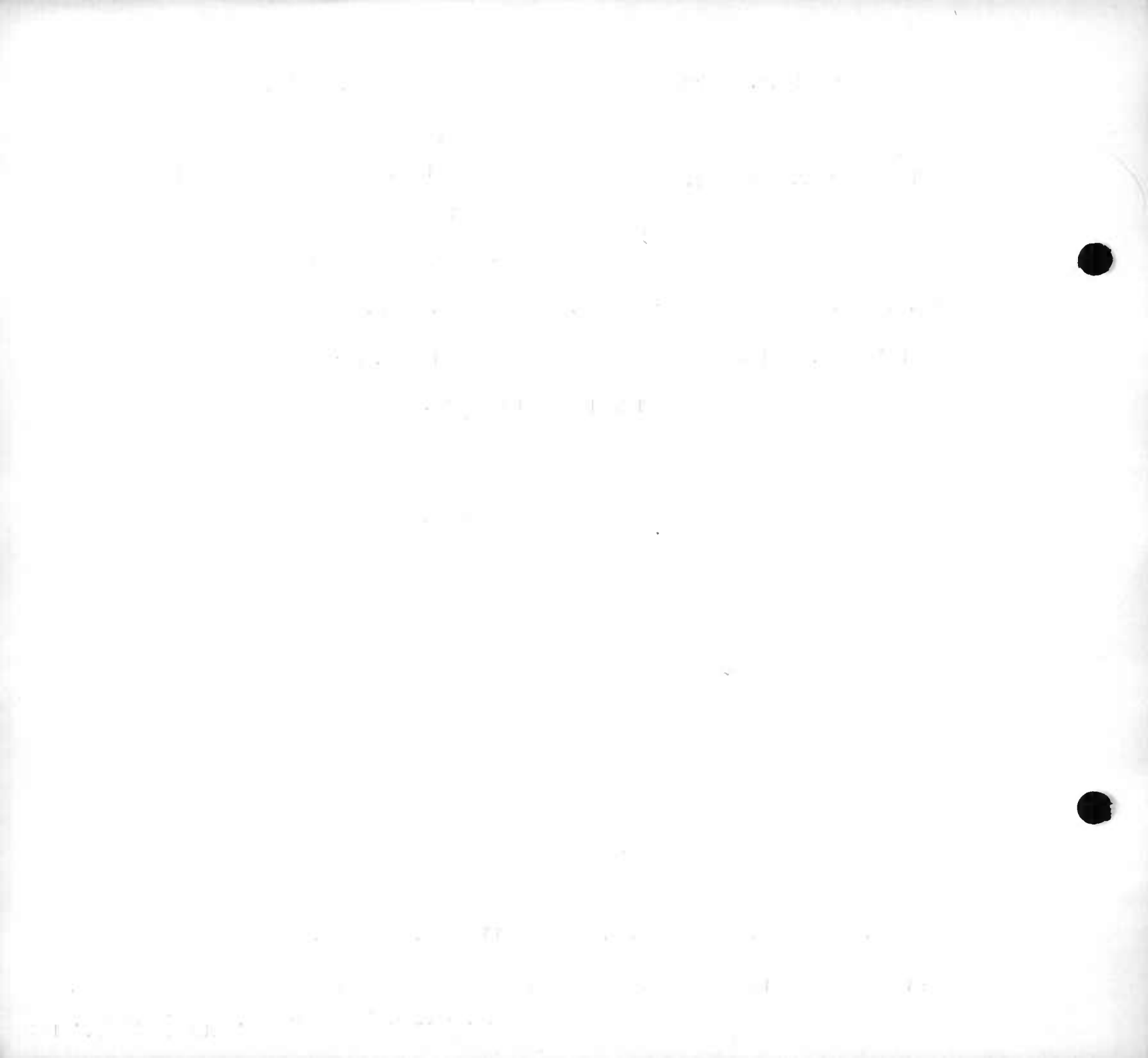
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 1612</u>
W-340 70 1612		70 1612 CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Philip H. Whittle</u>		2. DATE AND HOUR OF DEATH <u>Feb. 8, 1970</u> <u>1 12³⁰ P. M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2748</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>1210 Ramblewood Rd.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>5-26-03</u>		9. AGE (in years last birthday) <u>66</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Arnold Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William A. Whittle</u>		
14. MOTHER'S MAIDEN NAME <u>Alice C. Kraeger</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>157-10-3621</u>		17. INFORMANT <u>Ruth M. Whittle</u> ADDRESS <u>Same</u>		
18. <u>433.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Cerebral vascular thrombosis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral arteriosclerotic cardiovascular disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 yrs.</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> 19 <u>68</u> to <u>2-8</u> 19 <u>70</u> that (I) (we) lost saw the deceased alive on <u>1-29</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Alfred C. Ossman, Jr.</u>		23B. DATE SIGNED <u>2-9-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Alfred C. Ossman, Jr.</u>
23D. ADDRESS <u>1101 St. Paul St.</u>		23E. DEGREE <u>MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-11-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>
24D. LOCATION <u>Parkville, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>		
24F. NAME OF REGISTRAR <u>Robert E. Taylor, Md.</u>		24G. FUNERAL DIRECTOR <u>H. W. Jenkins Sons Co.</u>		
24H. ADDRESS <u>4905 York Rd. Baltimore, Md. 21212</u>		24I. ADDRESS <u>21212</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
M-255 70 1613					CERTIFICATE OF DEATH					
BIRTH NO.					REG. NO. 70 1613					
1. NAME OF DECEASED (Type or Print) <i>McNamee Francis John</i>					2. DATE AND HOUR OF DEATH <i>2/6 1970 3:06 pm</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>					A. STATE <i>MD</i>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. COUNTY					
C. CITY OR TOWN <i>Balto.</i>					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER <i>4712 Gledhill Street</i>										
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-3-1885</i>	9. AGE (in years last birthday) <i>84</i>	10. UNDER 1 Yr. Months: Days: Hours: Min.		11. UNDER 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Engineer</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Heating</i>			11. BIRTHPLACE (State or foreign country) <i>Unknown</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>McNamee</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>C. L. Webb</i>				ADDRESS <i>3026 St. Paul St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>ACVD. Acute Pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <i>2/6</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLINO OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>2/6</i> 19 <i>70</i> to <i>2/6</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>2/6</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <i>(I) (we)</i> (did) (did not) view the body after death.										
23A. SIGNATURE <i>D. P. van Kamen</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>2/6 70</i>		
23C. PHYSICIAN'S NAME (Type) <i>D. P. van Kamen</i> M.D.					23D. ADDRESS <i>Union Memorial Hospital 33rd Street Baltimore</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>2/10/70</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 10 1970</i>			25B. NAME OF REGISTRAR <i>Robert E. Hickey</i>			25C. FUNERAL DIRECTOR <i>H. W. Jenkins & Sons</i>			ADDRESS <i>C6. 4905 York Rd. Balto., Md. 21212</i>	

Cathedral & Madison St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 1614</u>	
S-315 70 1614		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Edward W. Stevens</u>			2. DATE AND HOUR OF DEATH <u>Feb. 8, 1970</u> <u>1 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1203</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>2802 Guilford Ave.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u>			6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lawyer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		8. DATE OF BIRTH <u>10-2-01</u>
13. FATHER'S NAME <u>James E. Stevens</u>			14. MOTHER'S MAIDEN NAME <u>Lilly B. Woodall</u>		9. AGE (in years last birthday) <u>68</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>219-30-1566</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
17. INFORMANT <u>Nancy E. Stevens</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cancer of Esophagus</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cancer of Esophagus</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>June 1969</u> to <u>Feb 5</u> 19 <u>70</u> that (I) <u>was</u> lost saw the deceased alive on <u>about Jan 27</u> 19 <u>70</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sol Smith</u>				23B. DATE SIGNED <u>2/9/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Sol Smith</u>				23D. ADDRESS <u>1261 E. Belvedere Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-11-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 10 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins Sons Co.</u>			
25D. ADDRESS <u>4905 York Rd.</u>		25E. ADDRESS <u>Baltimore, Md. 21212</u>			

2802 Guilford Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P.452 70 1615		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1615	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Agnes Theresa Plunkett		2. DATE AND HOUR OF DEATH Feb. 9, 1970 12 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		1202	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Longgreen Nursing Home		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER 3501 St. Paul Street			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-1887	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Timothy F. Sullivan		14. MOTHER'S MAIDEN NAME Mary Girty	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-50-9039		17. INFORMANT Mr. Paul J. Plunkett 215 Cedarcroft Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Gastrointestinal Hemorrhage</i> (B) <i>Stress ulceration?</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Cerebral vascular insufficiency</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i> <i>2 wks</i> <i>5+ yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Influenza</i>				<i>3 wks</i>	
19A. DATE OF OPERATION 8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>Feb</i> 19 <i>60</i> to <i>Feb 9</i> 19 <i>70</i> that (1) (we) last saw the deceased alive on <i>Feb 7</i> 19 <i>70</i> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Frederick J. Vollmer</i>		23B. DATE SIGNED <i>Feb 10, 1970</i>			
23C. PHYSICIAN'S NAME (Type) Dr. Frederick J. Vollmer		23D. ADDRESS 6100 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-12-70		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Md.		24E. NAME OF REGISTERAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
25A. DATE RECD BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTERAR		25D. ADDRESS 4905 York Road Balto., Md. 21212	

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J-525 70 1616
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
REG. NO. 70 1616

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2416 Harlem Ave. (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 2 8 70 2:25 P.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1605	
6. SEX M Negro	7. RACE C Male	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Jan. 4, 1901		10. AGE (In years lost birthday) 69		E. STREET AND NUMBER 2416 Harlem Ave.	
11. BIRTHPLACE (State or foreign country) Bel-Air Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James Westcott	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Alpenta Johnson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT George Johnson 2416 Harlem Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Russell S. Fisher, M.D. DATE SIGNED: 2-9-70 EXAMINER'S NAME (Type):					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/11/1970		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. FEB 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3199 Schroeder St.			

ACADEMIC BOND

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

YS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
2-100 70 1618		70 1618	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.		2/10/70, 4:00 AM	
1. NAME OF DECEASED (Type or Print)		M.	
ZEPP, Mr. Edgar			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
48 Maryland General Hosp.		Md. Baltimore 5300	
5. SEX		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
M	6. RACE	Baltimore	
W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	D. STREET ADDRESS (If rural, give location)	
	W	457 Lambert Ct.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH	
Welder		10/16/12	
10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Pittsburgh		57	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Baltimore, Md		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Lanard Zepp.		Ann Streb	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Unknown		220-05-9383	
17. INFORMANT		ADDRESS	
Family - NAME			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Gastric Carcinoma	
ANTECEDENT CAUSES		(A) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Respiratory arrest with metastasis	
		(B) DUE TO	
		Shock	
		(C) DUE TO	
		Acute renal failure, Sepsis, Gastric Ca.	
19. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)	
2		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from		21F. HOW DID INJURY OCCUR?	
that (I) (we) last saw the deceased alive on			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Enrique, A.		2/10/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
ENRIQUE, A.		Maryland Gen. Hosp.	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		2/13/70	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Glen Haven		Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
FEB 11 1970		Edgar Zepp, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
McCreary - 1306		Foul Air	

1913 - 1914

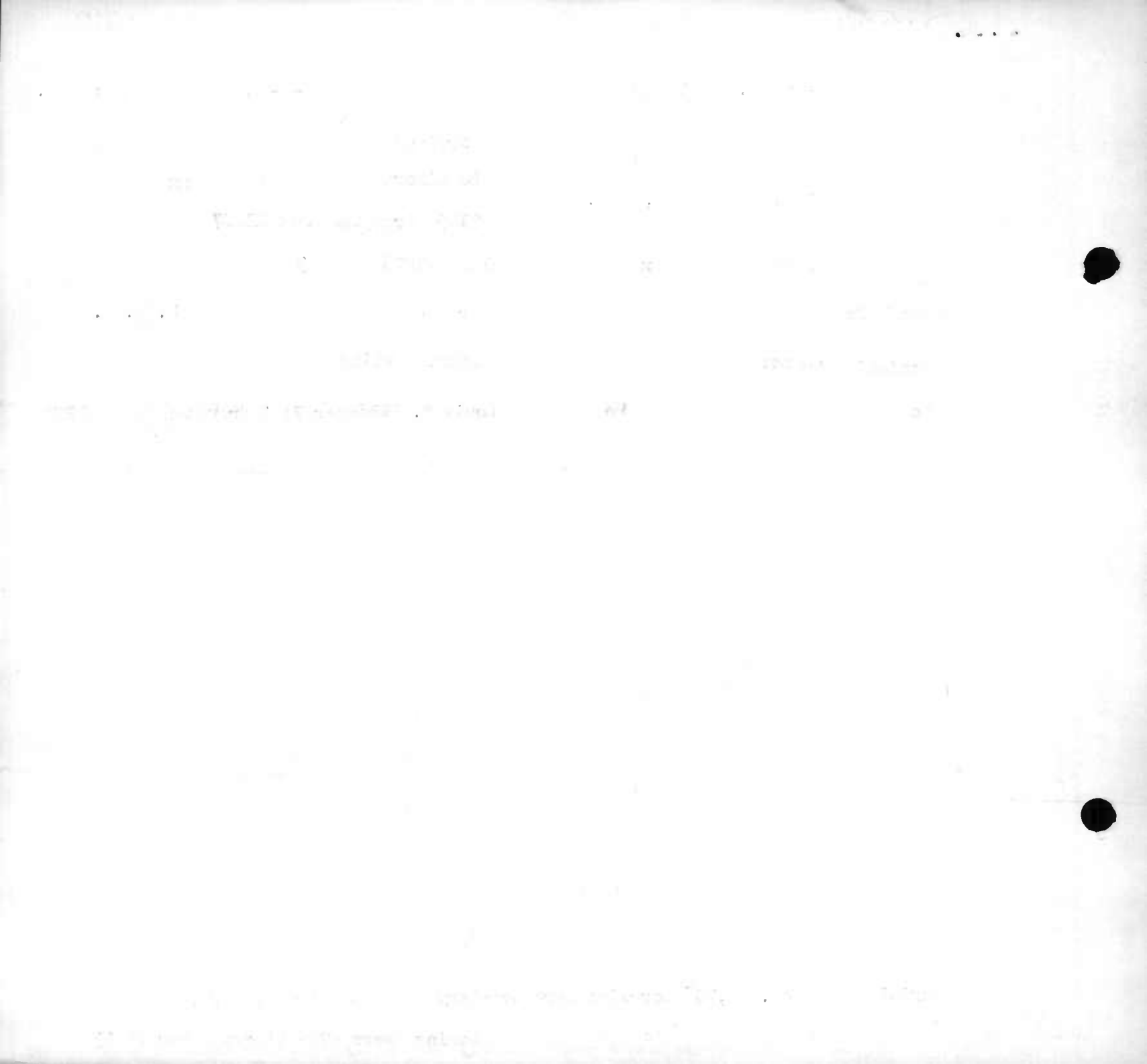
1913 - 1914

1913 - 1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

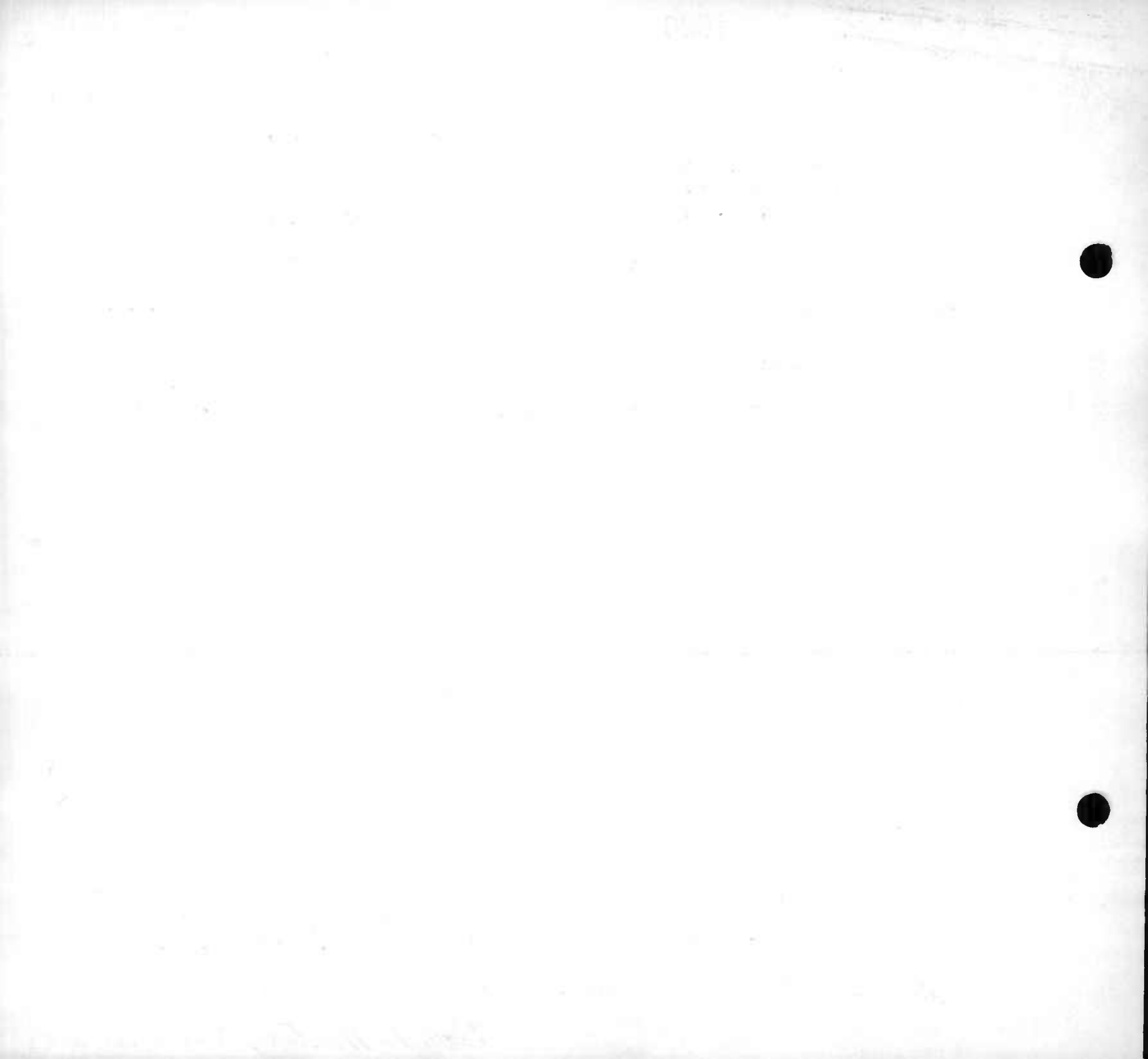
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1619	
<div style="display: flex; justify-content: space-between;"> S-535 70 1619 X </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Sadie E. Santmyer			2. DATE AND HOUR OF DEATH 2-8-70 12:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL, INC.			A. STATE Maryland B. COUNTY Baltimore Co.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 7103 Brompton Road 21207		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/1876	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Benjamin Joyner		
14. MOTHER'S MAIDEN NAME Laura Dowling			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. No			17. INFORMANT ADDRESS Louis W. Santmyer 7103 Brompton Road 21207		
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p>250.9 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>ACUTE MYOCARDIAL INFARCTION</p> <p>DIABETES MELLITUS</p> <p>ARTERIOSCLEROSIS</p> </div> <div style="flex: 0.5;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2-7-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Arteriosclerosis		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-7-1970 to 2-8-1970 that (I) (we) last saw the deceased alive on 2-8-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Randhir P. Sinha, MBBS				23B. DATE SIGNED 2-8-70	
23C. PHYSICIAN'S NAME (Type) RANDHIR P. SINHA, MBBS				23D. ADDRESS MERCY HOSPITAL, BALTO. Md. 21202	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Feb. 11, 70		Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State)		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Loring Byers, R.D.		25C. FUNERAL DIRECTOR ADDRESS Loring Byers 8728 Liberty Road 21133	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

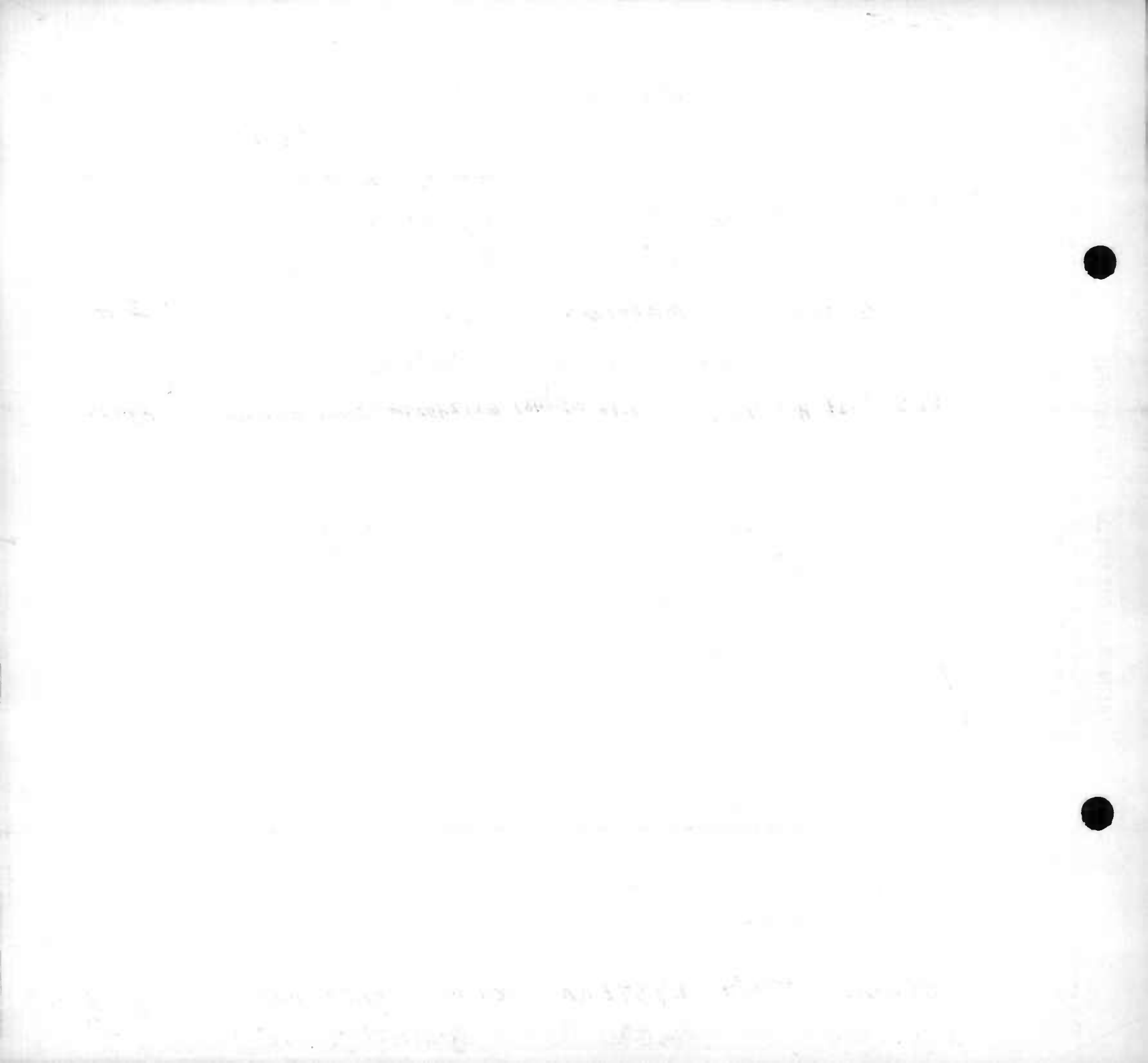
BALTIMORE CITY HEALTH DEPARTMENT				70 1620	
CERTIFICATE OF DEATH				REG. NO. 70 1620	
BIRTH NO. T-512 70 1620		1. NAME OF DECEASED (Type or Print) <u>DELILAH THOMPSON</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>1/29/70 11:30 P.M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore, Co</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1643 Hopewell Ave. 21221 005</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-92</u>	9. AGE (in years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Pleasant</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Evans</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>056 05 0582A</u>		17. INFORMANT <u>4940 Eastern Ave. ADDRESS</u> <u>BCH Records: Baltimore, Md. 21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>1/16/70</u> to <u>1/29/70</u> that (1) (we) last saw the deceased alive on <u>1/29/70</u> and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dale P. Henken, MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/29/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dale P. Henken</u>		23D. ADDRESS <u>Baltimore, City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>2-3-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St Stephens A.M.E.</u>	
24D. LOCATION (City, town, or county) <u>Essex, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>FEB 11 1970</u>			
24F. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		24G. FUNERAL DIRECTOR <u>Baltimore Mortuary 712 E. North Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> <h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>		REG. NO. <u>70 1621</u>	
1. NAME OF DECEASED (Type or Print) <u>George Zimmerman</u>		2. DATE AND HOUR OF DEATH <u>2-9-70</u> <u>5:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 Mercy Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u>	
5. SEX <u>M</u>		6. RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-11-93</u>	
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William W. Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hechter</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>216-81-8487</u>	
17. INFORMANT <u>ELIZABETH ZIMMERMAN</u>		ADDRESS <u>ABOVE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>250.91</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebrovascular Accident</u> (B) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus</u> (C)	
19A. DATE OF OPERATION <u>2.3.70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Arteriosclerosis</u>	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2.4.1970</u> to <u>2.9.1970</u> that (I) (we) last saw the deceased alive on <u>2.8.1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Randhir P. Sinha</u>		23B. DATE SIGNED <u>2-9-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>RANDHIR P. SINHA</u>		23D. ADDRESS <u>Mercy Hospital, Balto. MD 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>2/12/70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>WESTERN CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 11 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>General Funeral Home</u>		ADDRESS <u>3608 Hall Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

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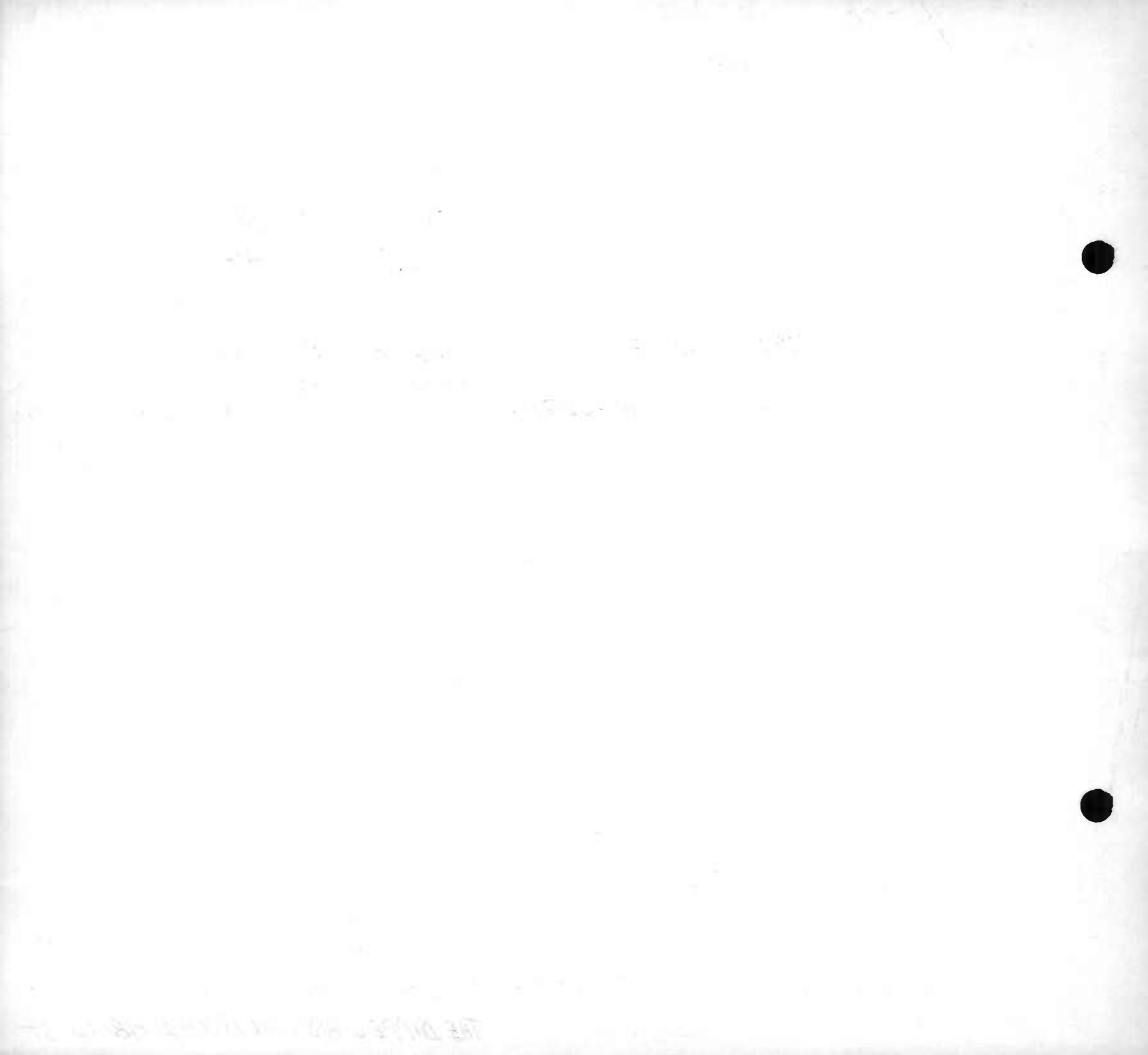
L-520		70 1622		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1622	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) LYONS, JAMES B.				2. DATE AND HOUR OF DEATH 2-9-70 17 45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY HARFORD			
FULL NAME OF HOSPITAL OR INSTITUTION Good SAMARITAN HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN KINGSVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 819 Petem Road							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-29-87	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chauffer		10B. KIND OF BUSINESS OR INDUSTRY private		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Malachy J. Lyons				14. MOTHER'S MAIDEN NAME Margaret Winn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213361933		17. INFORMANT ADDRESS Hospital records			
18. 436.9 + 1250.9 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 1. diabetes mellitus. 2. generalized atherosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 yr. 10-20 yr. 10 yr.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from 10-23-69 19 to 2-9-70 19, that (I) (we) last saw the deceased alive on 7 PM 2-9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death.							
23A. SIGNATURE Steve L Johnson				23B. DATE SIGNED 2-9-70		23C. PHYSICIAN'S NAME (Type) STEVE L JOHNSON MD	
23D. ADDRESS 11 KNOLL RIDGE CT. BALTIMORE, MD. 21210							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/12/70		24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert A. Taylor MD		25C. FUNERAL DIRECTOR COF. EVANS & SON		ADDRESS 8802 Harford road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1623	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>THERESA MARY YOUNG</i>		2. DATE AND HOUR OF DEATH <i>2/9/70</i> <i>8</i> <i>P</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE CITY</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>204 N. LINWOOD AVE</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/29/25</i>	9. AGE (in years last birthday) <i>44</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
13. FATHER'S NAME <i>ROY - LANG</i>			14. MOTHER'S MAIDEN NAME <i>AGNES BOWMAN</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>312-22-9937</i>		17. INFORMANT <i>HERBERT P YOUNG</i> <i>PATIENT'S HUSBAND</i> ADDRESS <i>204 N LINWOOD AVE</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>394.01</i> CAUSE OF DEATH <i>CEREBRAL EDEMA</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>36 HOURS</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CEREBRAL EDEMA, UNIL. HERNIATION</i>		
			(B) <i>EMBOLISM FROM PROSTHETIC MITRAL VALVE</i> DUE TO, OR AS A CONSEQUENCE OF: <i>30 HOURS</i>		
			(C) <i>RND C PROSTHETIC MITRAL VALVE</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>2/9</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indify medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2/8/70</i> 19 <i>70</i> to <i>2/9</i> 19 <i>70</i> that (I) (we) lost saw the deceased alive on <i>2/9</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Thomas Spencer Inui</i>				23B. DATE SIGNED <i>2/9/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>THOMAS SPENCER INUI</i>				23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL, 601 N. BROADWAY, BALTIMORE, MD.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>FEB 12 1970</i>		24C. NAME OF CEMETERY or CREMATORY <i>BALTIMORE NATIONAL CEM.</i>	
24D. LOCATION (City, town, or county) (State) <i>FREDERICK RD BALTO MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 11 1970</i>		25B. NAME OF REGISTRAR <i>John T. Kelly</i>	
25C. FUNERAL DIRECTOR <i>THE DUPPEL BROS INC</i>		ADDRESS <i>1800 E LOMBARD ST</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 2	
C-500 70 1624		70 1624	
1. NAME OF DECEASED (Type or Print) <i>Ralph R. Conway</i>		2. DATE AND HOUR OF DEATH <i>2-6-70 7:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2402</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 HALBORNEVIEW NURSING CENTER- 1213 Light St.</i>		C. CITY OR TOWN <i>Baltimore</i>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <i>704 E. FOLT AVE</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-15-24</i>
		9. AGE (In years lost birthday) <i>85</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	11. BIRTHPLACE (State or foreign country) <i>CANADA</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>JAMES</i>		14. MOTHER'S MAIDEN NAME <i>MARY E. McDoon</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>320-07-7784</i>	17. INFORMANT <i>FAMILY - JANE</i>
18. <i>412.31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: <i>H.S.C.V.D.</i> (B) <i>Coronary Heart failure</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Sclerosis</i> (C) <i>Amputation right leg</i>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>2/10</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CAUSING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>2/10</i> 19 <i>69</i> to <i>2/6</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>2/6</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Kenneth Kravitz</i>		23B. DATE SIGNED <i>2/7/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kenneth Kravitz MD</i>		23D. ADDRESS <i>115 W. Monument St.</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		24B. DATE <i>2-10-70</i>	
24C. NAME OF CEMETERY or CREMATORY <i>GLENN HAVEN</i>		24D. LOCATION (City, Town, or county) (State) <i>Baltimore</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 11 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>115 W. Monument St.</i>		25D. ADDRESS <i>115 W. Monument St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-250		70 1625		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 1625	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>DiCianni, Anthony</u>				2. DATE AND HOUR OF DEATH <u>2-10-70</u> <u>6:55 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Balto. Gen Hosp</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>md.</u>		B. COUNTY <u>Balto</u>		C. CITY OR TOWN <u>Lithicum</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <u>107 Twin Oaks Rd</u>		21090	
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-1-29</u>		9. AGE (in years last birthday) <u>40</u>		10. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>R.D. MOTORS</u>		11. BIRTHPLACE (State or foreign country) <u>Pa. (Philadelphia)</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph DiCianni</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Peiri</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Korean War</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Nancy H. DiCianni</u>				ADDRESS <u>107 Twin Oaks Rd. 21090</u>	
18. <u>238.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Brain tumor (post-operative)</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain tumor</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>1/28/70</u> 19 <u>70</u> to <u>2/10</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/10/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>S. M. Lyover, M.D.</u>				23B. DATE SIGNED <u>2/10/70</u>					
23C. PHYSICIAN'S NAME (Type) <u>Dr. S. M. Lyover</u>		23D. ADDRESS <u>South Baltimore Gen. Hospital - Baltimore, Md.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/13/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Sepulchre Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Germantown, Pa.</u>			
25A. DATE RECEIVED BY HEALTH DEPT. <u>FEB 11 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>McCallister</u>		ADDRESS <u>237 Patapsco Ave. 21225</u>			

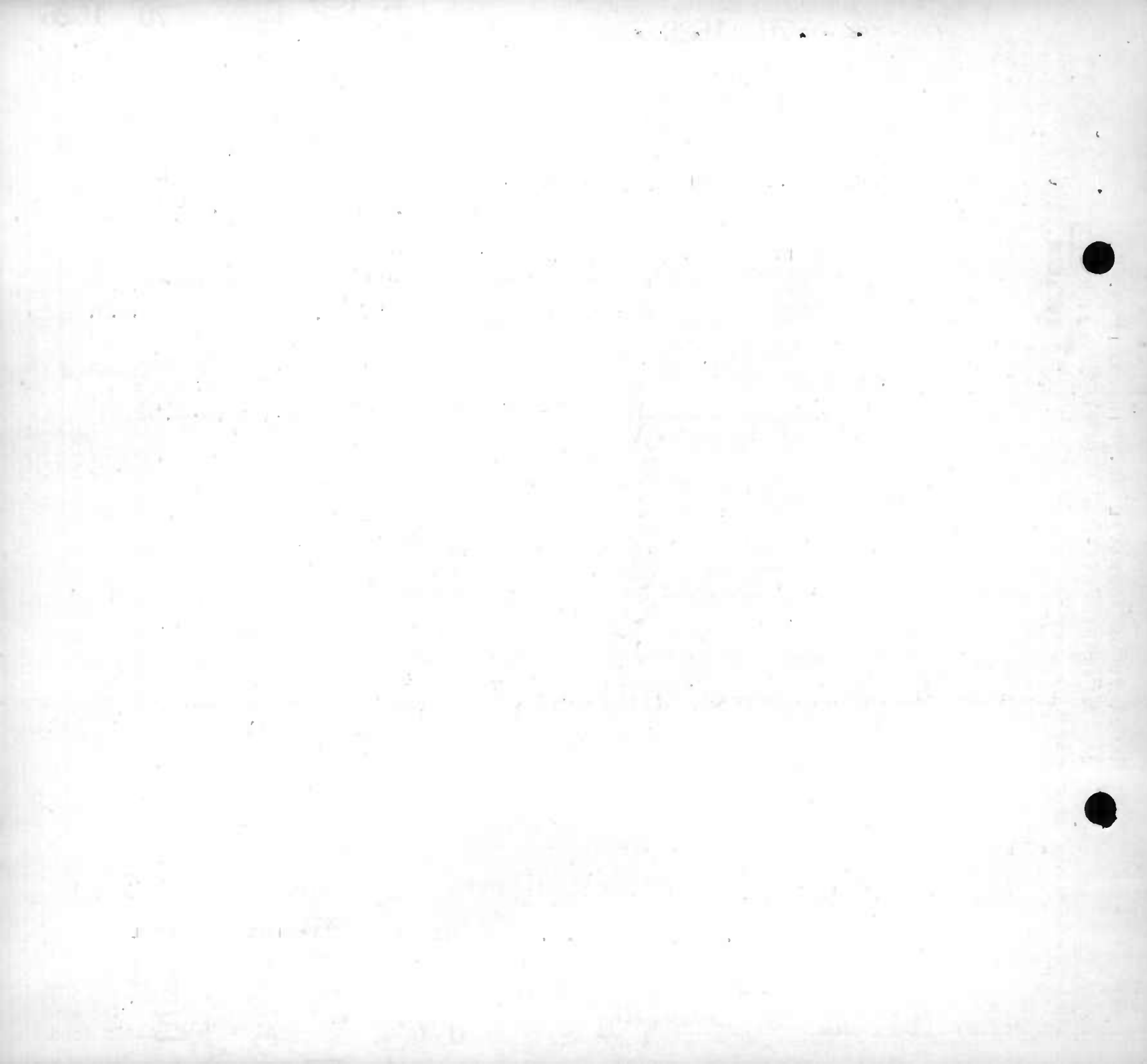
Operation 2-2-70 - per telephone conversation with record room.

2-16-70 - G. H.

8/22/71

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

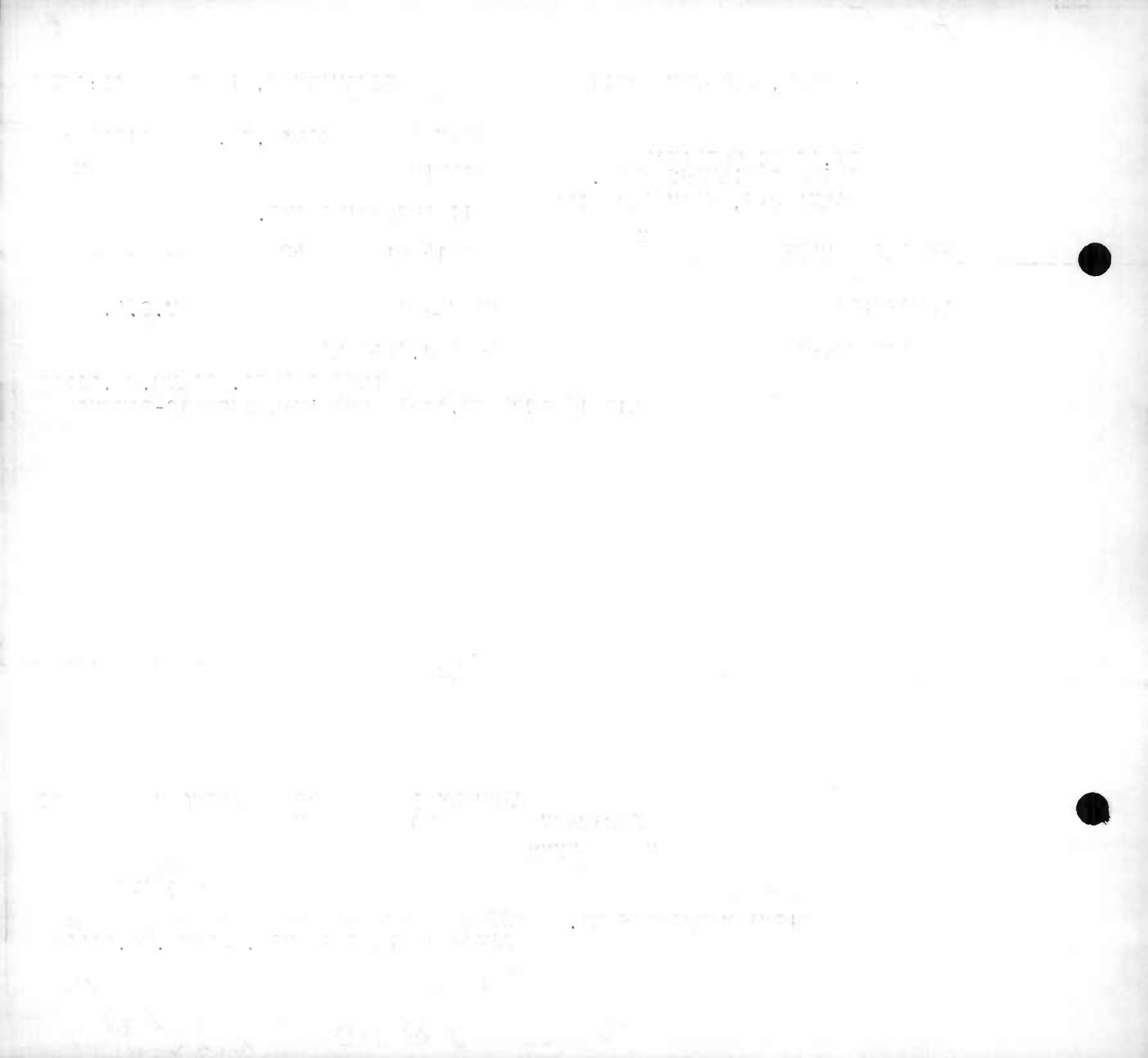
BIRTH NO. 8-246		70 1626		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1626	
1. NAME OF DECEASED (Type or Print) EDWIN ROESLER				2. DATE AND HOUR OF DEATH 2-5-70 6:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 500 N. HIGHLAND AVE. 21205			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-19	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Designer		10B. KIND OF BUSINESS OR INDUSTRY Prichard King		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Roesler				14. MOTHER'S MAIDEN NAME Annetta Keiser			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-4327		17. INFORMANT Mrs Elizabeth Roesler 500 N. Highland A			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). POLIOMYELITIS, PECTUS EXCAVATUM				CAUSE OF DEATH ACUTE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SUBBURAL HEMATOMA 26 hours ACUTE & CHRONIC ALCOHOLISM (BY HISTORY) (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2/4/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SUBBURAL HEMATOMA		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 500 N. HIGHLAND ST. 26-70			
21D. TIME OF INJURY (APPROX.) 2/4/70, 4pm		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL DOWN STEPS IN A STUPOR			
22. I certify that (this hospital) attended the deceased from 2/4 1970 to 2/5 1970, that (I) last saw the deceased alive on 2/5 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE James K. Condon M.D.						23B. DATE SIGNED 2/5/70	
23C. PHYSICIAN'S NAME (Type) JAMES K. CONDON M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-9-1970		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville Balto Md	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. Bailey		25C. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
H-125		70 1627		70 1627	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HOBSON, DOROTHY MARIE		FEBRUARY 8, 1970 12:15PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229			A. STATE B. COUNTY MARYLAND BALTO. CO. 2122853-00		
CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 611 INGLESIDE AVE.					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 14 21	9. AGE (In years last birthday) 48	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME GEORGE TURNER			14. MOTHER'S MAIDEN NAME ANNA J. (HOERL)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217 16 7004		
17. INFORMANT WILKENS AVES. BALTO. MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 183.0 I This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE Peritonitis DUE TO, OR AS A CONSEQUENCE OF: (B) Ca of Ovary DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 3 19 70 to FEBRUARY 8 19 70 that (I) (we) last saw the deceased alive on FEBRUARY 8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pricha Boonswang, M.D. DEGREE				23B. DAY SIGNED 2/08/70	
23C. PHYSICIAN'S NAME (Type) PRICHA BOONSWANG MD. PRICHA BOONSWANG M.D. DEGREE				23D. ADDRESS CATON & WILKENS AVES. BALTO. MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2/11/70		24C. NAME of CEMETERY or CREMATORY LORRAINE PARK Co.	
24D. LOCATION Balto.		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR E. J. [Signature] 301 Frederick Rd Baltimore	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-632		70 1628		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1628	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) ANDREW JOSEPH FRITZ.				2. DATE AND HOUR OF DEATH 2/8/70 11:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2402			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GENERAL HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1147 N. E. Side Ave.			
5. SEX MALE	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-77	9. AGE (in years last birthday) 92	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10B. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME PETER				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT FAMILY - SAME		ADDRESS	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Renal failure, Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic cardiovascular disease				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal failure, Pneumonia		(B) DUE TO, OR AS A CONSEQUENCE OF: disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/9/70 to 2/8 19 70 that (I) (we) last saw the deceased alive on 2/8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 2/8/70			
23C. PHYSICIAN'S NAME (Type) DR. CECILIA A. CHEN				23D. ADDRESS 3001 S. HANOVER STREET.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2-13-70		24C. NAME of CEMETERY or CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) BALTIMORE	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]		ADDRESS 1300 E. Fort Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-400		70 1629		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70-1629	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FEELLEY, ANNA Rebecca				2. DATE AND HOUR OF DEATH FEB. 8 - 70 7 40 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md., Baltimore B. COUNTY 53-00				C. CITY OR TOWN			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSP. 4940 Eastern Avenue Baltimore, Maryland 21224		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-21-00		9. AGE (in years last birthday) 69 Y	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Tavern Owner		11. BIRTHPLACE (State or foreign country) Md., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN MULLANEY		14. MOTHER'S MAIDEN NAME ANNA UHL				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -			
16. SOCIAL SECURITY NO. 219-32-1120		17. INFORMANT BCH-Records				ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
18. 432.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Thrombosis of Basilar artery, aspiration pneumonia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: artery, aspiration pneumonia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) DUE TO, OR AS A CONSEQUENCE OF: Acute Hydrocephalus + herniation				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 2-7-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Poss. Cerebellar		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (A) (this hospital) attended the deceased from Feb. 7 19 70 to Feb. 8 19 70 that (B) (we) last saw the deceased alive on Feb. 8 19 70 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE MEHDI SARKARATI M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Feb 8/70					
23C. PHYSICIAN'S NAME (Type) MEHDI SARKARATI M.D.		23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/12/70		24C. NAME of CEMETERY or CREMATORY Parkwood Cem		24D. LOCATION (City, town, or county) (State) Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Valerie E. Sargent		25C. FUNERAL DIRECTOR Thos. J. Thompson		ADDRESS 1600 Hollins St.			

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1630

BIRTH NO. 0-540

1. NAME OF DECEASED
(Type or Print)

John T. O'Neill

2. DATE OF DEATH Known ☒ Estimated ☐
Month Day Year Hour

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3. DATE PRONOUNCED DEAD Month Day Year Hour
2 3 70 12:00 pm.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 402

6. SEX male
7. RACE white

B. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH

9/19/1898

10. AGE (In years lost birthday) 71

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

712 W. Fayette St.

11. BIRTHPLACE (State or foreign country)

Philadelphia Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unknown

14B. KIND OF BUSINESS OR INDUSTRY

Unknown

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes No WAR II

17. SOCIAL SECURITY NO.

2-14-24-52-18

18. INFORMANT

Mrs. Bernadette Pagnetas 1315 Number Rd.

ADDRESS

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
NO

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐
Deputy Chief Medical Examiner

DATE SIGNED

2/3/70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/10/70

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 11 1970

25B. NAME OF REGISTRAR

Robert E. Bailey, M.D.

25C. FUNERAL DIRECTOR

John J. Bowman, Jr.

ADDRESS

901 St.

NO 1000

NO 1000

REPUBLIC OF THE PHILIPPINES

1951

AGRICULTURE

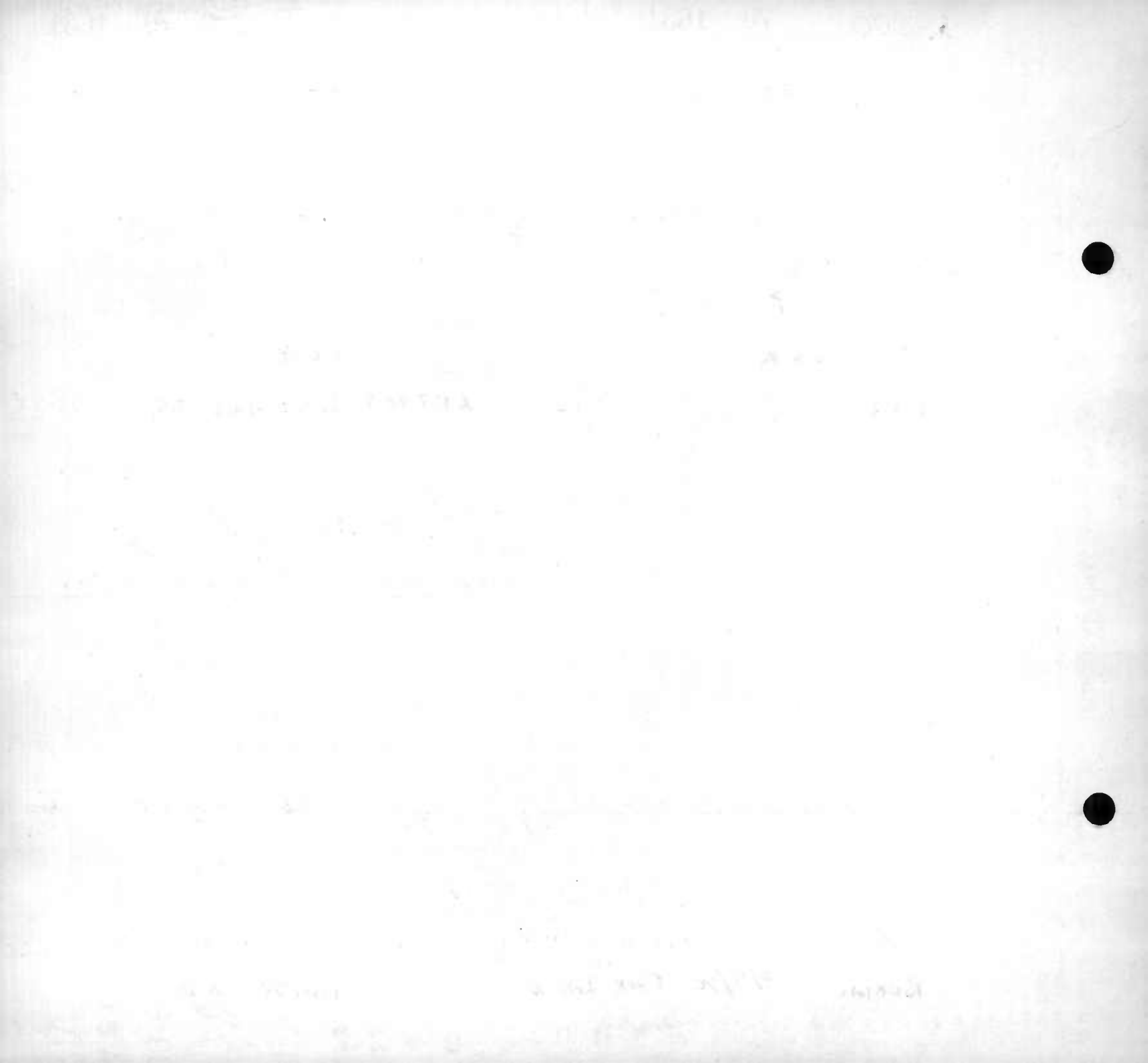
1951

13/1/51

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-000		70 1631		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1631	
1. NAME OF DECEASED (Type or Print) Lloyd Lee				2. DATE AND HOUR OF DEATH 2-6-70 2:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Center				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 675 Bangert St. - White Marsh, Md.			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-1912	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME VNK			14. MOTHER'S MAIDEN NAME VNK				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) VNK			16. SOCIAL SECURITY NO. 086-14-6077		17. INFORMANT LUTHER WILLIAMS JR		ADDRESS ABOVE
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) antecedent heart disease DUE TO, OR AS A CONSEQUENCE OF: chronic heart disease (C) cerebral thrombosis & paralysis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
19A. DATE OF OPERATION 2/12/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/25 19 68 to 2/6 19 70 , that (I) (we) last saw the deceased alive on 2/6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE all mappin				23B. DATE SIGNED 2/6/70			
23C. PHYSICIAN'S NAME (Type) ALLAN H. MYNATT MD				23D. ADDRESS 2 E Pearl St BALT MD 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2/9/70		24C. NAME OF CEMETERY or CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970				25B. NAME OF REGISTRAR John E. ...		25C. FUNERAL DIRECTOR Bolton Hill Nursing & Convalescent Center	
				ADDRESS Essex md			



FUNERAL DIRECTOR: IMPORTANT

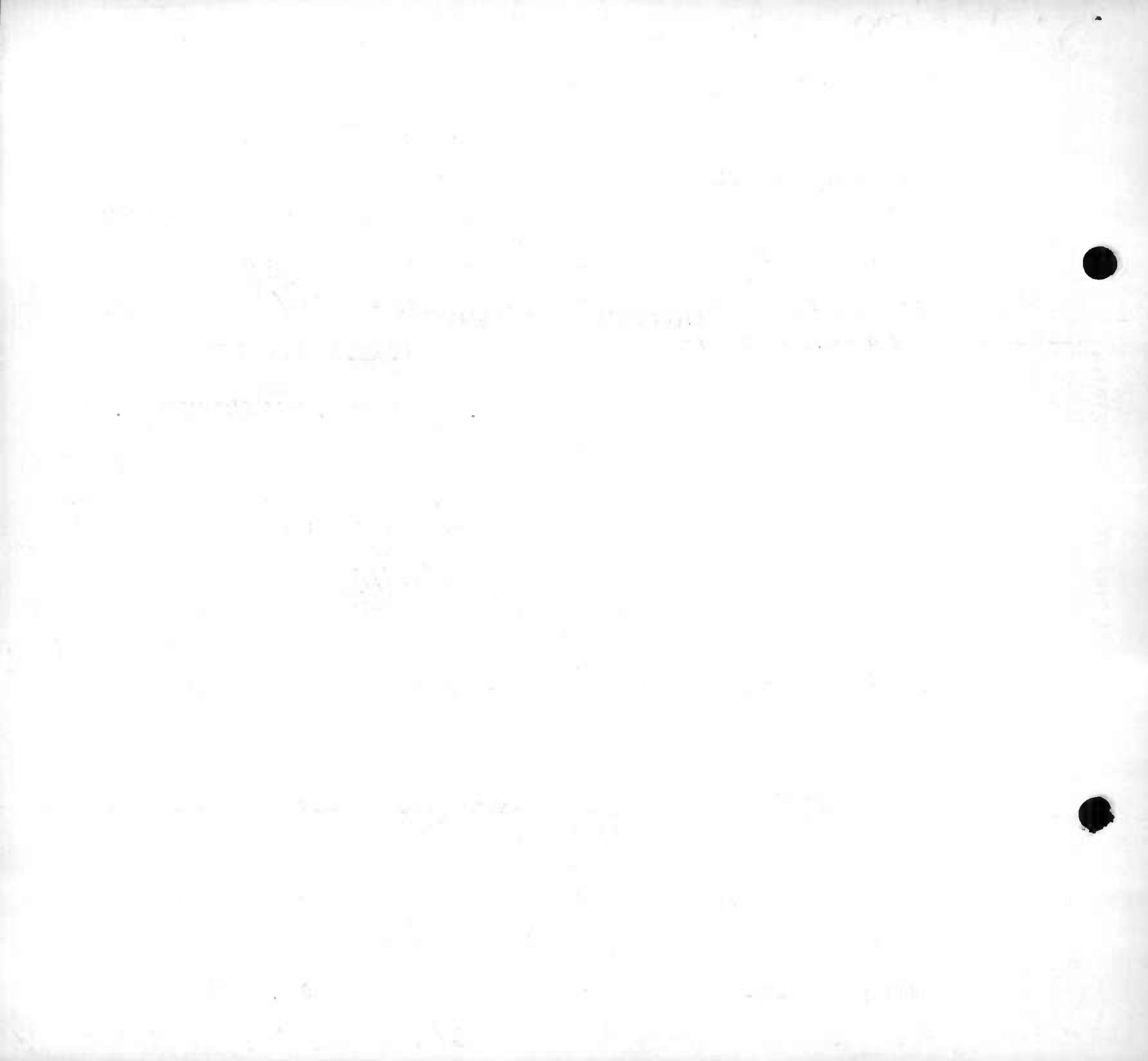
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-340		70 1632		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1632	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mrs. Doris Dudley				2. DATE AND HOUR OF DEATH 2-6-70 4:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2706			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-31-10	
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Marian Bennett		14. MOTHER'S MAIDEN NAME Anna Gruber		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-24-3081	
17. INFORMANT Robert H. Dudley - 6305 Fernbank Ave.		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiopulmonary Failure days		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic carcinoma of rectum		(B) DUE TO, OR AS A CONSEQUENCE OF: Peritonitis		(C) ?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Peritonitis		21. DATE OF OPERATION 1-21-70		22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
23. DATE OF OPERATION 1-21-70		24. CONDITION FOR WHICH OPERATION WAS PERFORMED carcinoma, rectum		25. AUTOPSY? (Yes or No) Yes		26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes		30. HOW DID INJURY OCCUR?	
31. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		32. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		33. DATE SIGNED 2-6-70		34. ADDRESS	
35. I certify that (I) (this hospital) attended the deceased from 1-19-70 to 2-6-70		36. and that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		37. SIGNATURE Lucas C. Vidler		38. PHYSICIAN'S NAME (Type)	
39. BURIAL CREMATION, REMOVAL (Specify) Burial		40. DATE 2/10/70		41. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		42. LOCATION (City, town, or county) (State) Baltimore Maryland	
43. DATE REC'D BY HEALTH DEPT. FEB 11 1970		44. NAME OF REGISTRAR Robert C. Altenburg		45. FUNERAL DIRECTOR Robert C. Altenburg		46. ADDRESS 6009 Harford Rd. - Balto., Md. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

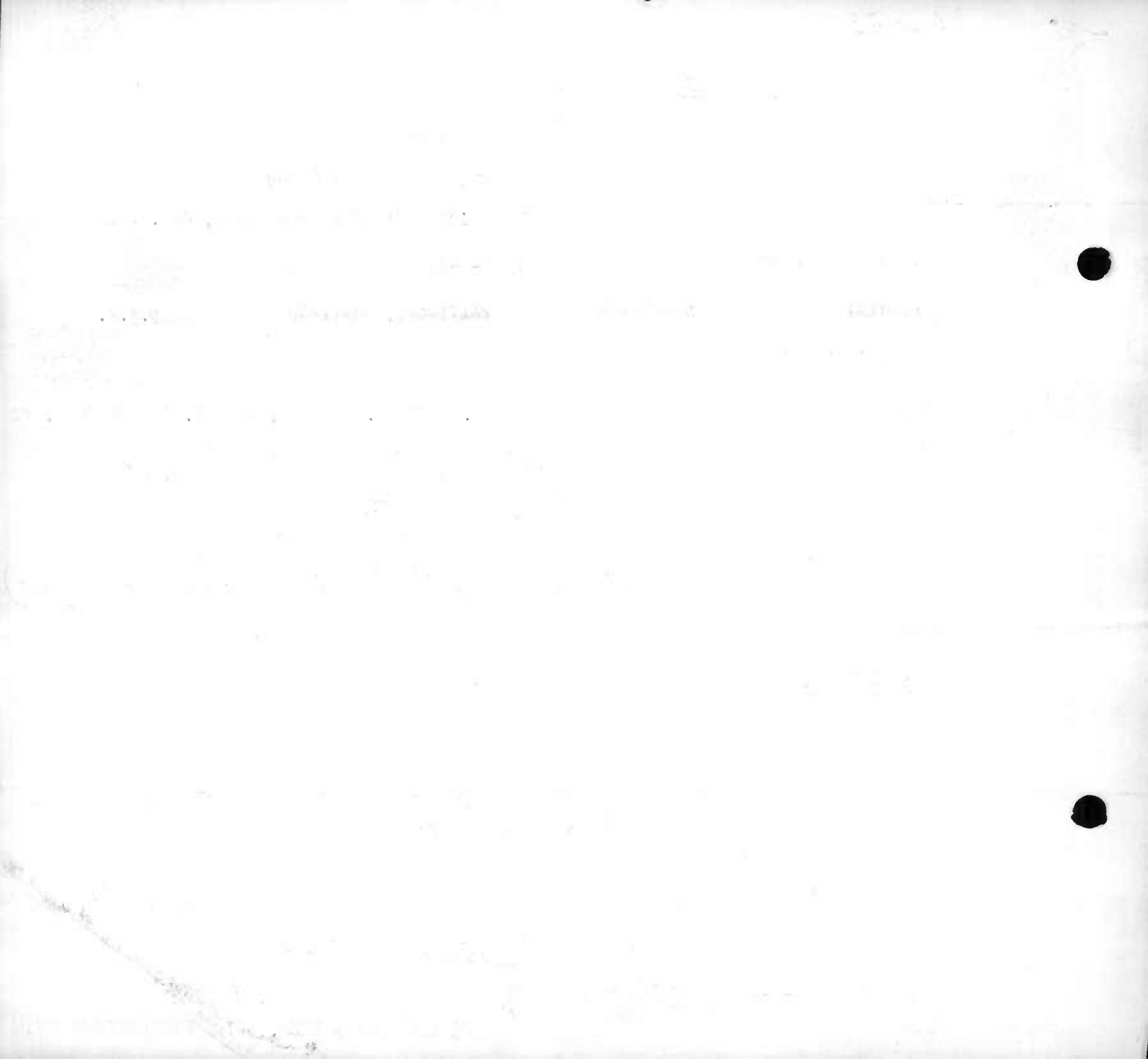
C-500		70 1633		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1633	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) COHEN, LAWRENCE. BERNARD			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH FEB 9 / 70 1035 AM			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL 38				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY XXXXXXX C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5911 East Cliff Dr. 21209			
5. SEX male	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/26/46	9. AGE (In years last birthday) 23	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY FAIRCHILD HILERS ELECTRICAL		11. BIRTHPLACE (State or foreign country) XXXXXX - Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL COHEN				14. MOTHER'S MAIDEN NAME XXXXXX WOLFE BESSIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. SAMUEL COHEN, 5911 EASTCLIFF DR. #9			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 563.0 I REGIONAL Ileitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: REGIONAL Ileitis (B) DUE TO, OR AS A CONSEQUENCE OF: GASTRIC ULCER & FISTULA, RECURRENT (GASTROINTESTINAL) (C) DUE TO, OR AS A CONSEQUENCE OF: REGIONAL Ileitis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 1/2 YRS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ILEO COLIC-PUTANEUS FISTULA, RECURRENT ILEO VESICAL FISTULA LEFT EMPYEMA, LT. SUBPHRENIC ABSCESS							
19A. DATE OF OPERATION 7-8-69 1-12-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED APX. 12 OPERATIONS FOR		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? intern. Heartly			
22. I certify that We At (this hospital) attended the deceased from March 4 Aug 1961 to Feb 9 1970 that (I) (we) last saw the deceased alive on Feb 9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Miguel H. Gonzalez M.D.				23B. DATE SIGNED Feb 9/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) MIGUEL H. GONZALEZ M.D.				23D. ADDRESS UNIVERSITY OF MARYLAND HOSP. BALTO, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-10-70		24C. NAME of CEMETERY or CREMATORY BNAI ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. Taber, Md.		25C. FUNERAL DIRECTOR Oliver Anderson & Bros.		ADDRESS 1010 Annapolis Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

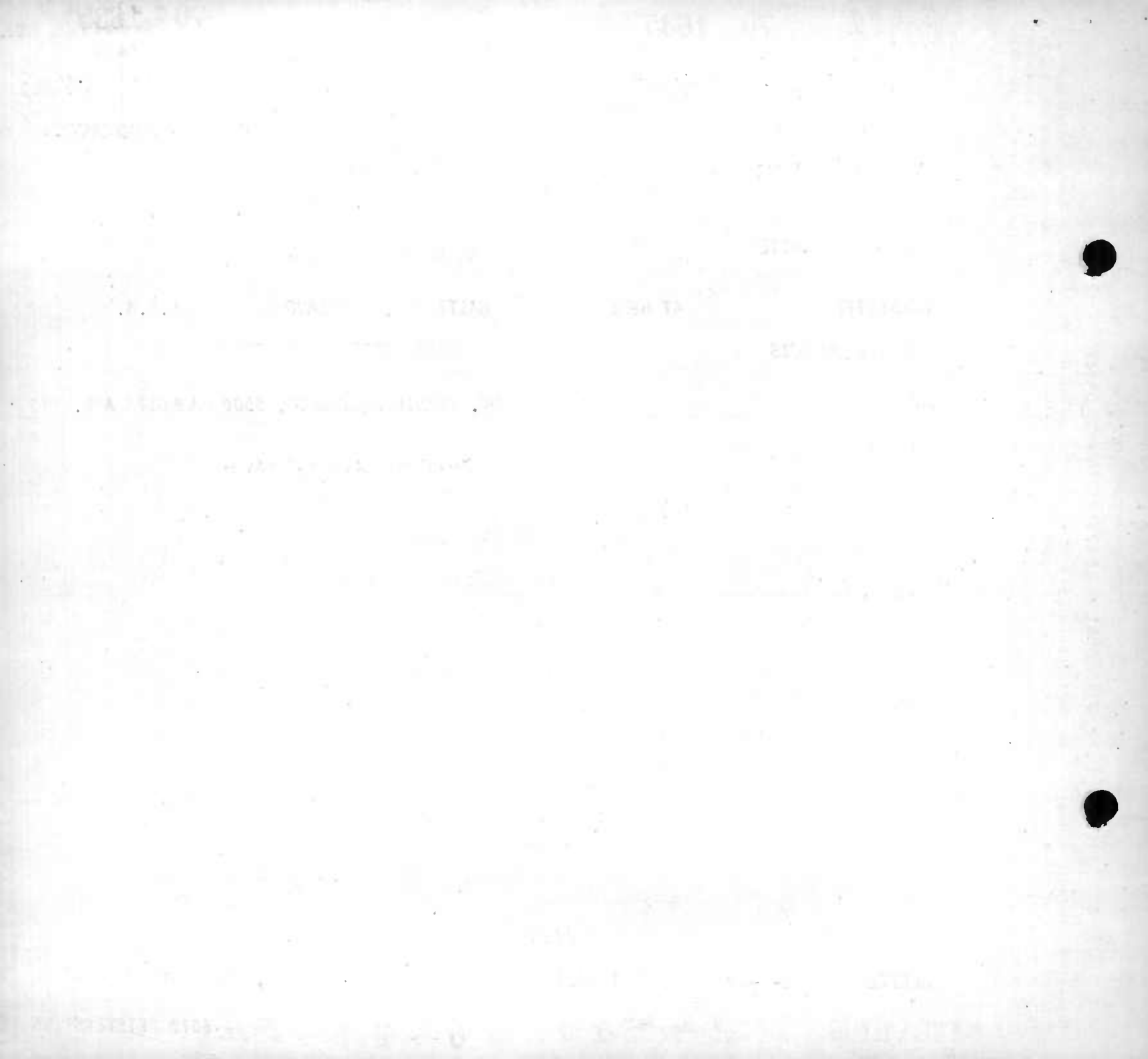
N-253 70 1634		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 1634
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Nochumowitch, Shirley</i>		2. DATE AND HOUR OF DEATH <i>2.6.70 1:30 p.m.</i>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>42 SINAI HOSPITAL</i>		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>BALTIMORE, MD</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI HOSPITAL</i>		E. STREET AND NUMBER <i>6964 MILBROOK PARK DRIVE, APT. T 2</i>		
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>7-8-1928</i>	9. AGE (In years last birthday) <i>41</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MEDICAL</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>SECRETARY</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>ABRAHAM SYKES</i>		
14. MOTHER'S MAIDEN NAME <i>ANNIE SYKES</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		
16. SOCIAL SECURITY NO.		17. INFORMANT <i>MR. ERWIN B. FRENKIL, 612 CT. SQUARE BLDG. #2</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>174 X I</i> <i>Profound GI Bleeding from Multiple ulcers Gastric & duodenal</i> <i>Metastatic tumor Liver from Breast Ca - Metastatic</i> <i>tumor Adrenal Glands - Post</i> <i>(C) Adrenalectomy - Corticotherapy (Replacement)</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. AUTOPSY? (Yes or No)		
21A. DATE OF OPERATION <i>2.5.70</i>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Metastatic Ca Liver</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22. I certify that (I) (this hospital) attended the deceased from <i>2.5</i> 19 <i>70</i> to <i>2.6</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>2.5</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>R. Theodore</i>		
23B. DATE SIGNED <i>2.6.70</i>		23C. PHYSICIAN'S NAME (Type) <i>ROGER THEODORE</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>2-8-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>GREATER BALTIMORE LODGE</i>
24D. LOCATION <i>BALTIMORE, MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>FEB 11 1970</i>		
25B. NAME OF REGISTRAR <i>Robert E. Jaber, Jr.</i>		25C. FUNERAL DIRECTOR <i>SOD LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

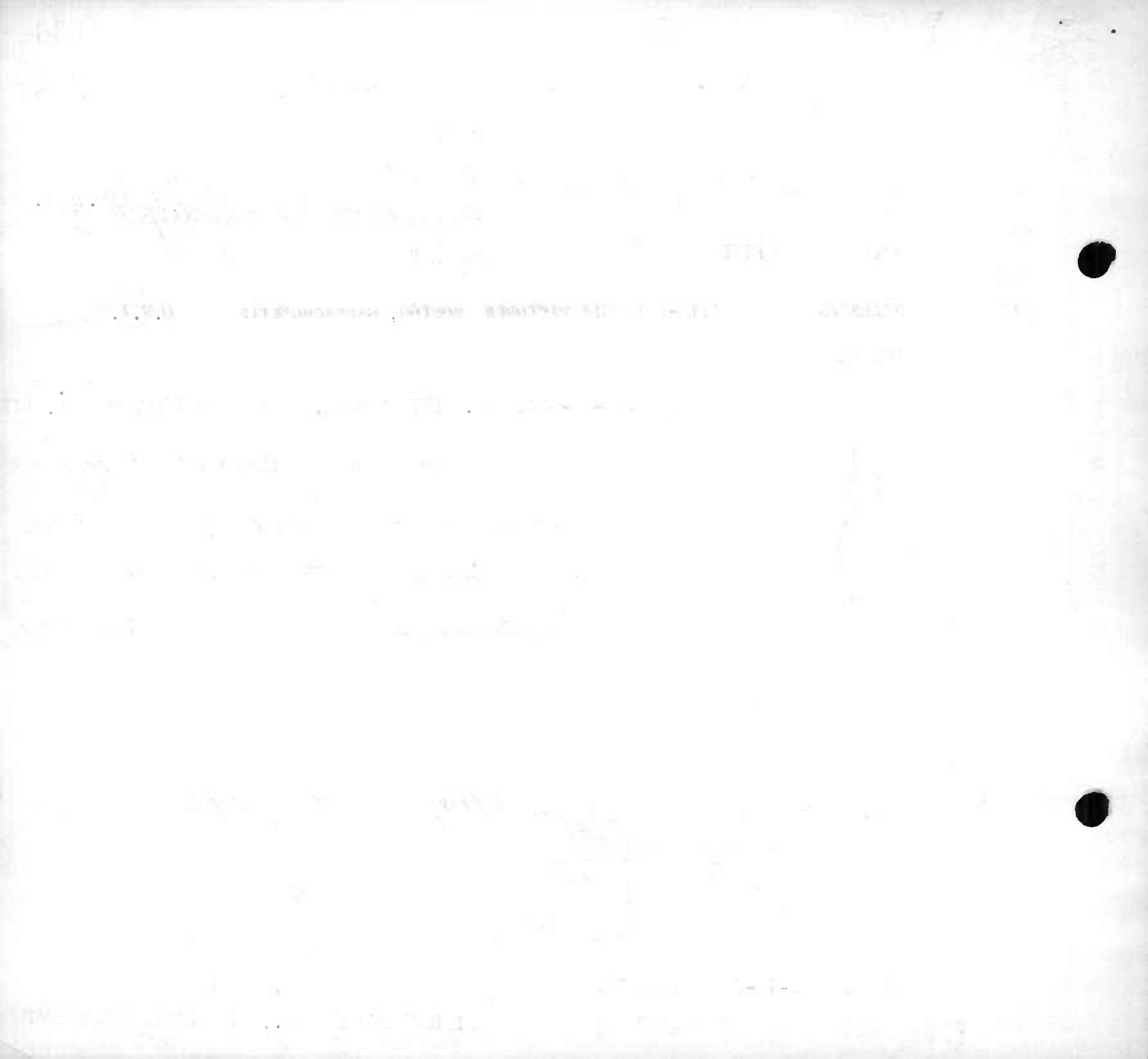
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 1635
BIRTH NO. H-422		AGE 70		DATE OF DEATH 1899
1. NAME OF DECEASED (Type or Print) IDA R. HOLZSWEIG		2. DATE AND HOUR OF DEATH 02-06-70 7:30 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5500 MAGNOLIA AVE.		
5. SEX FEMALE	6. RACE W. HITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-22-09	9. AGE (In years lost birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MAURICE DU BOIS		
14. MOTHER'S MAIDEN NAME SARAH REIF		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 212032305		17. INFORMANT MR. BERNIE HOLZSWEIG, 5500 MAGNOLIA AVE. #15		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARRHYTHMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Sepsis Denmotomyositis Steroid therapy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 2/5	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 2/5 19 70 to 2/6 19 70 , that (I) (we) last saw the deceased alive on 2/6 4 AM 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.				
23A. SIGNATURE Harvey G. Klein MD		23B. DATE SIGNED 2/5/70		
23C. PHYSICIAN'S NAME (Type) HARVEY G. KLEIN M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 2-8-70	24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Goldstein & Bros.
VS 150-REV. 1/1/68		ADDRESS 6010 REISTERSTOWN RD		



FUNERAL DIRECTOR: IMPORTANT

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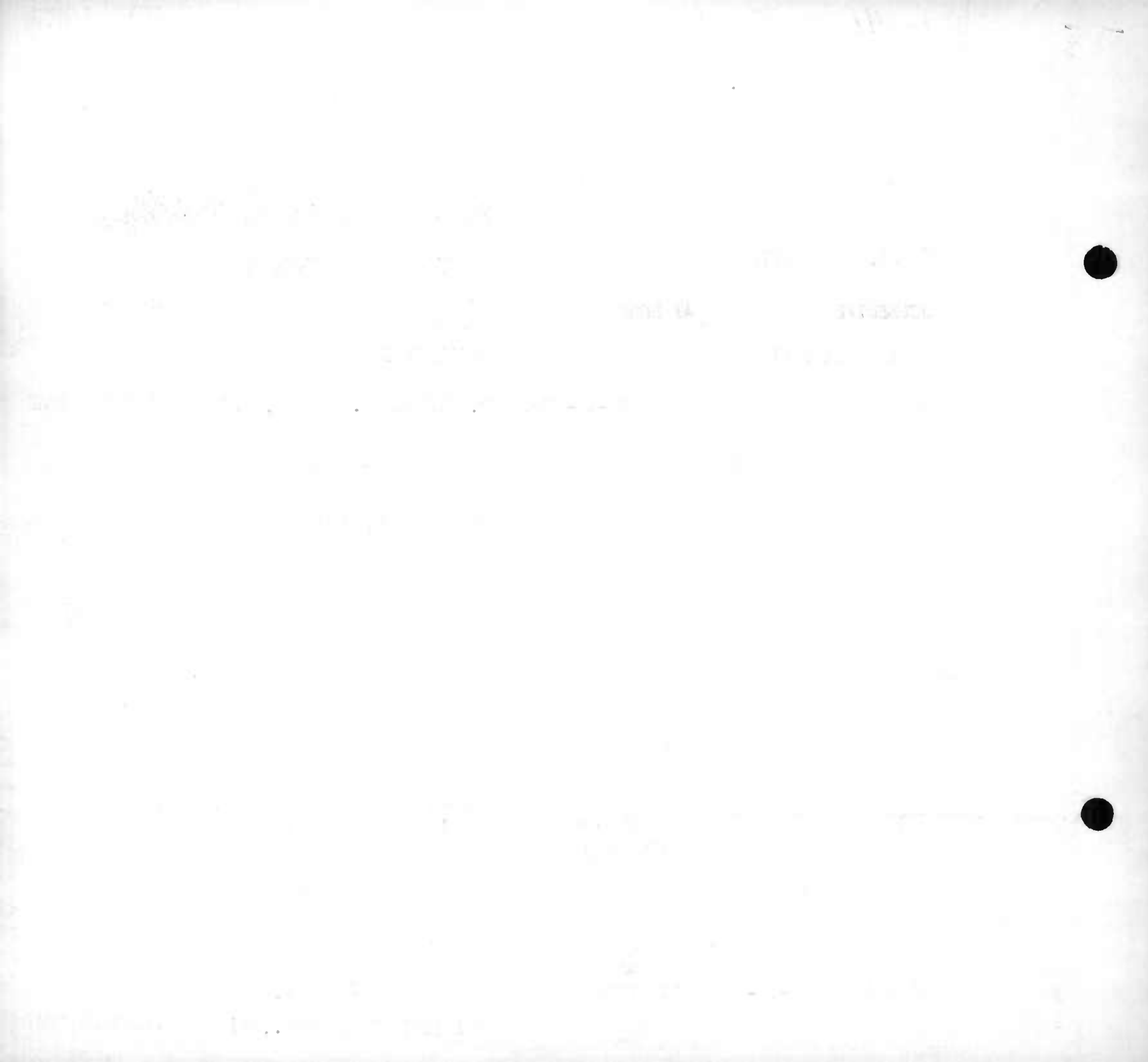
S-255 70 1636		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1636	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Jack Susman</i>		2. DATE AND HOUR OF DEATH <i>2/8/70 7:55 A.M.</i>	
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY		2740	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Balto. Inc</i>		C. CITY OR TOWN <i>BALTO</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>MALE</i>		6. RACE <i>WHITE</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>10/27/05</i>		9. AGE (in years last birthday) <i>64</i>		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>FILM-COLUMBIA PICTURES BOSTON, MASSACHUSETTS</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>092-01-3708</i>		17. INFORMANT <i>MRS. BETTY SUSMAN, 5904 CROSS COUNTRY BLVD. #15</i>	
18. <i>153.8 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pulmonary embolism</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Post-op. Streptococcal</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Carcinoma of the colon</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>20 days</i> <i>months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Septicemia</i>				<i>25 days</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> 1970 to <i>2/8</i> 1970 that (I) (we) last saw the deceased alive on <i>2/8/70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Carlos R. Perez</i>		23B. DATE SIGNED <i>2-10-70</i>		23C. PHYSICIAN'S NAME (Type) <i>Carlos R. Perez M.D.</i>	
23D. ADDRESS <i>Sinai Hospital of Balto</i>		23E. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		23F. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>2-10-70</i>		24C. NAME of CEMETERY or CREMATORY <i>LUBAWITZ</i>	
24D. LOCATION <i>ROSEDALE, MARYLAND</i>		24E. CITY, town, or county		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 11 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>	



FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> 0-641 70 1637 BALTIMORE CITY HEALTH DEPARTMENT 70 1637 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. _____
BIRTH NO. _____		2. DATE AND HOUR OF DEATH 2-9-70 9.10 a.m.
1. NAME OF DECEASED (Type or Print) <u>Sadye S. ORLOVE</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Balto</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LEVINDALE HEBREW HOME & INF.</u> <u>91</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>3600 LABYRINTH ROAD</u> XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		8. DATE OF BIRTH <u>8-XX-98</u> 9. AGE (in years last birthday) <u>XX XX 71</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>ADOLPH SILBGER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZ KLEIN</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-32-7742</u> 17. INFORMANT ADDRESS <u>MR. STANLEY J. ORLOVE, 8309 BURNINGWOOD ROAD</u>
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD + Parkinson's Ds.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>Years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____
22. I certify that (I) (this hospital) attended the deceased from <u>8-18-1966</u> to <u>2-9-1970</u> that (I) (we) last saw the deceased alive on <u>2-9-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>2-9-70</u>
23C. PHYSICIAN'S NAME (Type) <u>JOSE ARDAIZ</u>		23D. ADDRESS <u>7 OBERLIN Ct. Towson, Md.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>2-10-70</u>
24C. NAME OF CEMETERY OR CREMATORY <u>BETH TFILOH</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
25A. DATE REC'D. BY HEALTH DEPT. <u>FEB 11 1970</u>		25B. NAME OF REGISTRAR <u>SOO LEVINSON</u>
25C. FUNERAL DIRECTOR ADDRESS <u>BROS., 6010 REISTERSTOWN ROAD</u>		25D. _____



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. [REDACTED]
C-651		70		1638
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <i>Crumpler, James King</i>		2. DATE AND HOUR OF DEATH <i>2/4/70</i> <i>732 P M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1604</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>909 607 Pennsylvania Ave. Btmd 21201 George Washington Nursing Home</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>Male</i>		6. RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>
13. FATHER'S NAME <i>Dennis Crumpler</i>		14. MOTHER'S MAIDEN NAME <i>Mary Devone</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>225-18-0813-A</i>		17. INFORMANT <i>OLETA CRUMPLER</i> ADDRESS <i>SAME. Chart 607 Penna Ave</i>
18. <i>436.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>STROKE</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Generalized Arteriosclerosis</i>		(B) DUE TO OR AS A CONSEQUENCE OF: <i>Congestive Heart Failure</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>1 Dec 1969</i> to <i>6 Feb 1970</i> , that (I) (we) last saw the deceased alive on <i>6 Feb 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Richard Tyson M.D.</i>		23B. DATE SIGNED <i>9 Feb 70</i>		
23C. PHYSICIAN'S NAME (Type) <i>Richard Tyson</i>		23D. ADDRESS <i>2320 Eutaw Place; Baltio. Md. 21217</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2-10-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Mem. Pk. Balto., Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 11 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>		25C. FUNERAL DIRECTOR <i>Kelson A. H. [illegible]</i>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

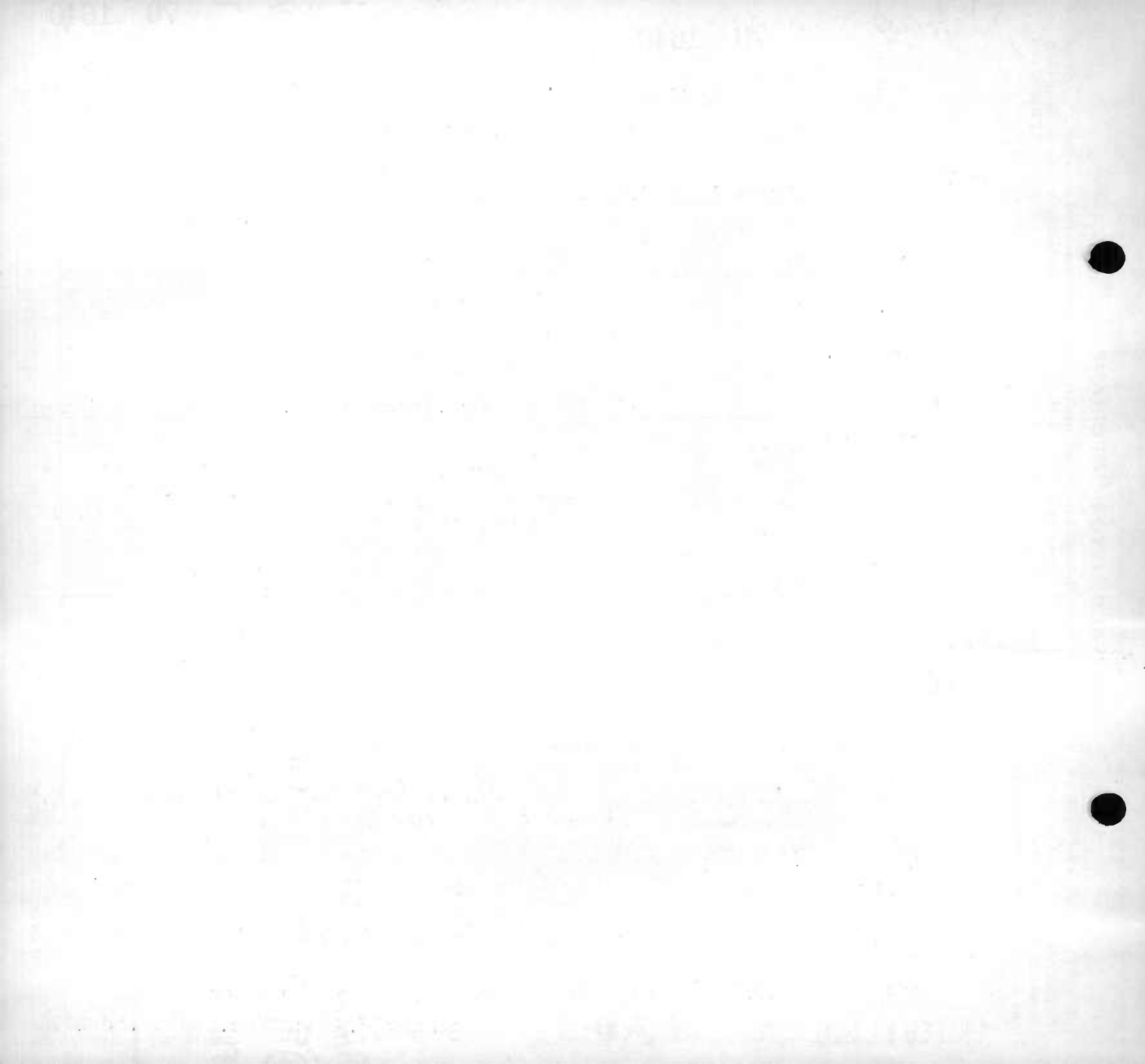
H-230		70 1639		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1639	
1. NAME OF DECEASED (Type or Print) EDWARD ARTHUR HACKETT				2. DATE AND HOUR OF DEATH FEB. 8, 1970 7:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION US PUBLIC HEALTH SERVICE HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD.		B. COUNTY BALTO. CITY	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3804 OLD FREDERICK RD. 21229			
5. SEX Male	6. RACE Negroid	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-06	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER - RET.		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES HACKETT				14. MOTHER'S MAIDEN NAME ELSIE PAGE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES US Army 1942-46		16. SOCIAL SECURITY NO. 216-70-9400		17. INFORMANT ELY HACKETT		ADDRESS HOSPITAL CHART - WIFE - SAME	
18. 519.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY FAILURE				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RESPIRATORY FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC OBSTRUCTIVE LUNG DISEASE				(B) CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF: 5 YEARS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from FEB 5, 1970 to FEB 8, 1970 that (we) last saw the deceased alive on FEB - 8, 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Irving D. Wolfe, M.D.				23B. DATE SIGNED 2/8/70		23C. PHYSICIAN'S NAME (Type) IRVING D. WOLFE, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2/10/70		24C. NAME OF CEMETERY OR CREMATORY BALTO. NAT'L. CEM.		24D. LOCATION (City, town, or county) (State) BALTO. Odd.	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert F. Bailey		25C. FUNERAL DIRECTOR W. R. BAILEY		ADDRESS 1348 N. CALHOUN ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

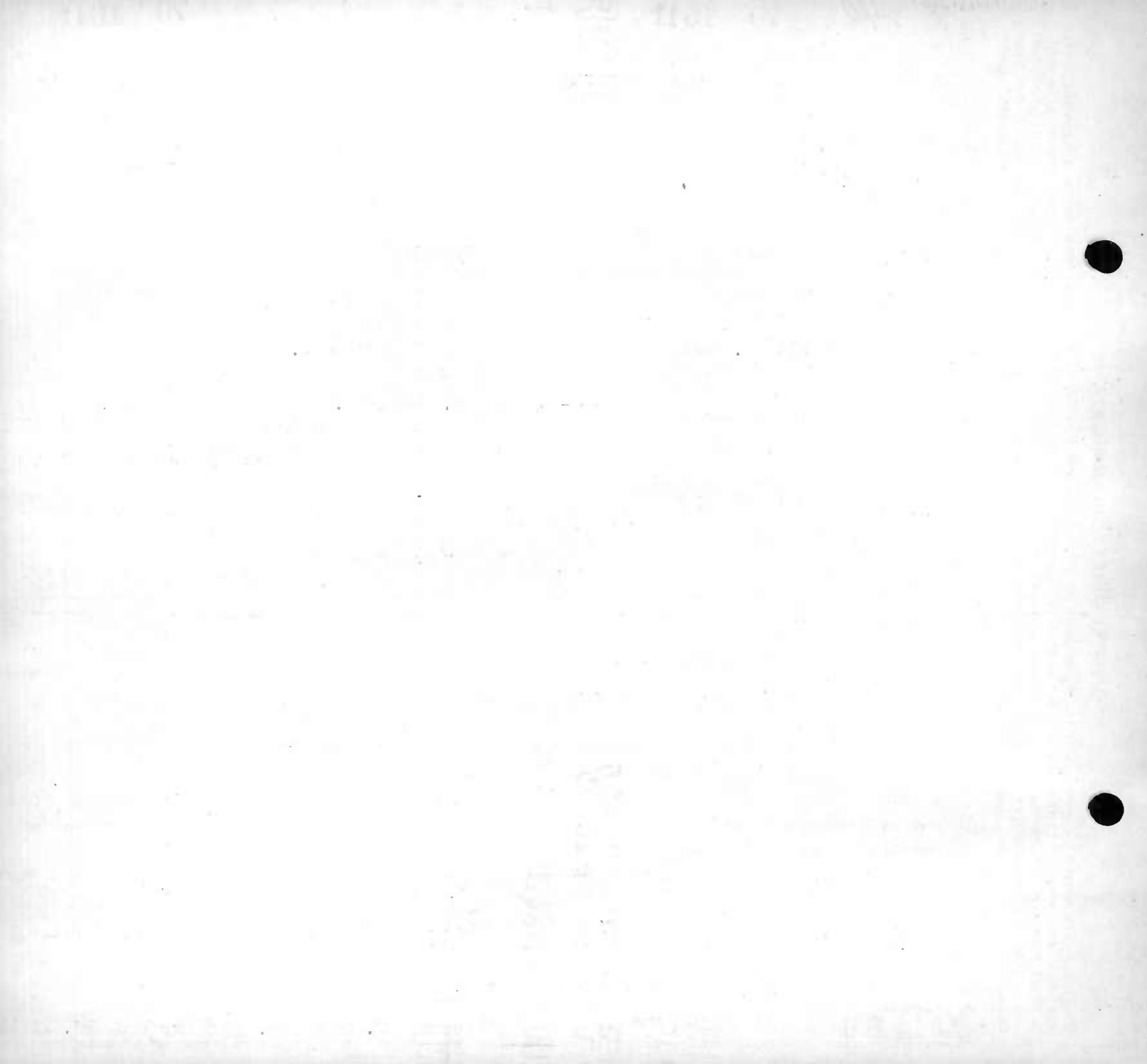
BALTIMORE CITY HEALTH DEPARTMENT				70 1640		REG. NO. 70 1640	
BIRTH NO. 7-000				70 1640 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) a ELMER B. RAY SR.				2. DATE AND HOUR OF DEATH February 6, 1970 658 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 99 UNION MEMORIAL HOSP D.O.A.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2706 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2801 Hamilton Ave.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/1901	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. (Retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Harry S. Ray				
14. MOTHER'S MAIDEN NAME Blanche Boyer			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 215077663			17. INFORMANT ADDRESS Mrs. Margaret E. Ray- 2801 Hamilton Av				
18. CAUSE OF DEATH 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive and } many arteriosclerotic cardio- } years vascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 1964 to Feb. 6 1970 , that (I) (we) last saw the deceased alive on Feb. 3 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Hans J. Koetter				23B. DATE SIGNED 2/7/			
23C. PHYSICIAN'S NAME (Type) HANS J. KOETTER				23D. ADDRESS 5800 Harford Road # 21214			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/9/70		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
BIRTH NO.				70 1641	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Pearl Durkee Bauerle			Feb 6 1970 3:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 380 6 Chesley Ave.			Maryland 2735		
5. SEX			6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female			Caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH			9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
7/13/1891			78		Homemaker
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Maryland			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles W. Busick			Ella V. Stible		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
			705-05-7498 D		Mr. George L. Bauerle
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
412.4 I			Stokes Adams Syndrome		4 yrs.
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Arteriosclerotic Cardiovascular Disease with Aortic and Mitral Valvular Disease		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 1966 to Feb 1970, that (I) (we) lost saw the deceased alive on 9 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Frank T. Kasik Jr.				2/6/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Frank T. Kasik Jr.				9005 HARFORD RD BALTO	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		2/10/70		Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
FEB 11 1970		Robert E. Fisher		Leonard J. Mack Inc. 5305 Harford Rd. 21211	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

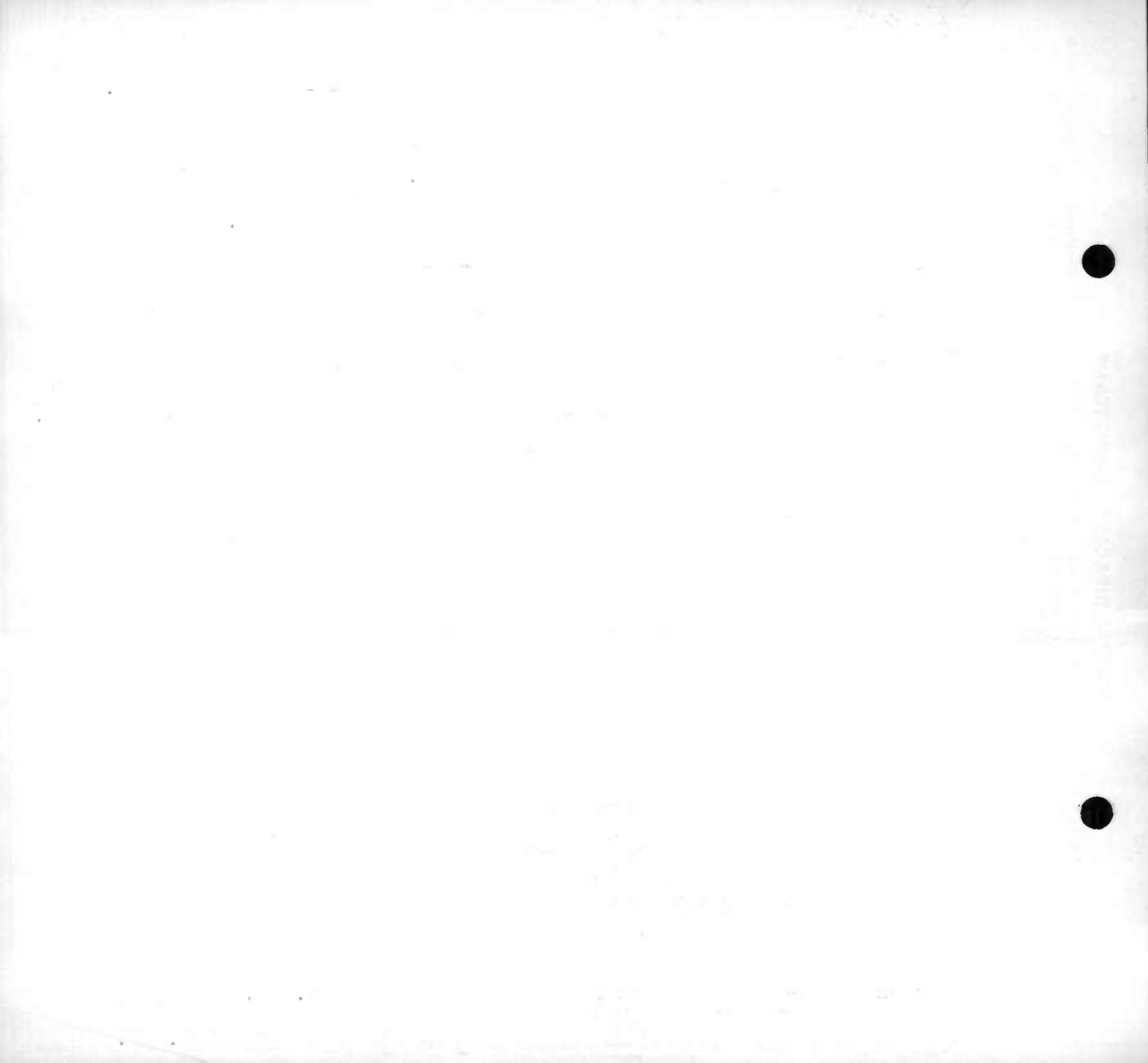
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 1642</u>	
C-450 70 1642		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Edward L Cullum</u>		2. DATE AND HOUR OF DEATH <u>2/8/70</u> <u>5:40</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Balto. Inc</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>27-17</u>	
		C. CITY OR TOWN <u>Balto</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>Belvedere Ave. at Greenspring</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/04</u>
		9. AGE (In years last birthday) <u>66</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bar Tender</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick L Cullum</u>	
14. MOTHER'S MAIDEN NAME <u>Ida M Taylor</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>218-18-6774</u>		17. INFORMANT <u>Mr Margaret E Cullum</u>	
18. ADDRESS <u>Same</u>		19. CAUSE OF DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (AI stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus</u> (C) <u>Acute Pulmonary edema</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>23 days.</u> <u>8 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> 19 <u>70</u> to <u>2/8</u> 19 <u>70</u> that (I) <u>(we)</u> last saw the deceased alive on <u>2/7</u> 19 <u>70</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.			
23A. SIGNATURE <u>Charles R. Perel MD</u>		23B. DATE SIGNED <u>2/8/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles R. Perel MD</u>		23D. ADDRESS <u>Belvedere Ave. at Greenspring</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/11/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE, RECORD, HEALTH DEPT. <u>FEB 11 1970</u>		25B. NAME OF REGISTRAR <u>George J. Buck Inc.</u>	
25C. FUNERAL DIRECTOR <u>George J. Buck Inc.</u>		ADDRESS <u>Baltimore, Maryland</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

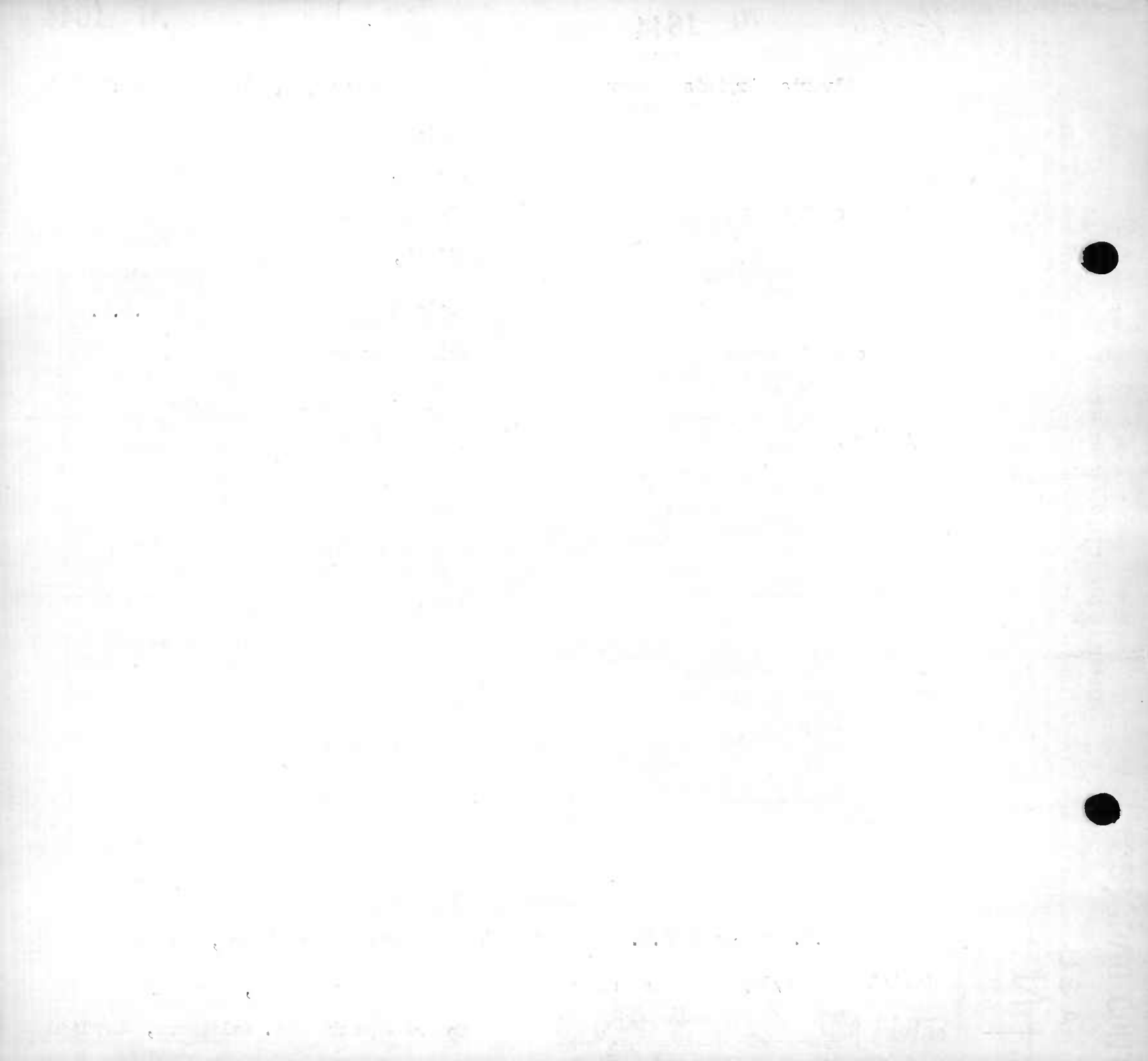
E-420		70 1643		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1643	
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
FRANCES ELLIS				2-7-70 10.55 AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
37 MERCY HOSPITAL				Maryland			
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F				W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife						12-25-1895	
11. BIRTHPLACE (State or foreign country)				9. AGE (In years lost birthday)		11. Under 1 Yr. Months Days	
Maryland				74		11. Under 24 Hrs. Hours Min.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
USA				Bernard Mc Ginnity			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			
Mary O'Keefe				No			
16. SOCIAL SECURITY NO.				17. INFORMANT			
217-48-7599				Mr Lewis D Ellis 6600 Eastern Prkwy.			
18. CAUSE OF DEATH				ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				21214			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Broncho pneumonia			
				(B) Overwhelming stress			
				(C) Infected ulcer of ankle			
II				Parkinson's disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 1-16-70 to 2-7-70 that (1) (we) lost saw the deceased alive on 2-7-70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
MANUELA M. RIBEIRO, M.D.				2-8-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MANUELA M. RIBEIRO, M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		2-11-70		Parkwood		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.				25C. FUNERAL DIRECTOR		ADDRESS	
FEB 11 1970				Leonard J Ruck Inc Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1644	
<div style="display: flex; justify-content: space-between;"> P-360 70 1644 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Alverta Virginia Potter		February 8, 1970 5:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 2818 Hamilton Ave		A. STATE Maryland B. COUNTY 2706			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 21, 1914		9. AGE (In years last birthday) 55		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas E Street		14. MOTHER'S MAIDEN NAME Mollie Briscoe	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr Henry C Potter	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Carcinoma of Ovary</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 8 - 1966</i> to <i>Feb 8 1970</i> , that (I) (we) last saw the deceased alive on <i>1-10-70</i> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>G. J. Sawyer Jr M.D.</i>				23B. DATE SIGNED <i>2/9/70</i>	
23C. PHYSICIAN'S NAME (Type) G. J. Sawyer Jr M.D.				23D. ADDRESS 4808 Harford Rd Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/10/70		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR Leonard J. Ruck		24F. ADDRESS Inc. Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR <i>Robert E. [Signature]</i>		25C. FUNERAL DIRECTOR Leonard J. Ruck	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-230		70 1645		BALTIMORE CITY HEALTH DEPARTMENT		70 1645	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) ALBERT A. BASTA				2. DATE AND HOUR OF DEATH 2/6/70 12:10 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 45 GOOD SAMARITAN HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 901 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 531 E 41ST STREET			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-18	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Basta				14. MOTHER'S MAIDEN NAME Anna Bellman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 217-03-2145		17. INFORMANT Mrs Alice M Basta		ADDRESS Same	
18. 185X + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Prostate (B) — metastatic lesions DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes, Azotemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 1 month	
19A. DATE OF OPERATION 1/11/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ureteral obstruction		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/22 19 69 to 2/6 19 70 , that (I) (we) last saw the deceased alive on 2/6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jeffrey D. Neill MD DEGREE				23B. DATE SIGNED 2/6/70			
23C. PHYSICIAN'S NAME (Type) Jeffrey D. Neill MD DEGREE				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/10/70		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Leonard J. Buck Inc.		ADDRESS Baltimore, Maryland	

Caroline & Berta

— Metastatic lesions

Diabetes, Asokina

Diabetes Asokina

NO

Diabetes

Diabetes

11/12/11

11/12/11

11/12/11

John Hopkins

John Hopkins

John Hopkins

FUNERAL DIRECTOR: IMPORTANT

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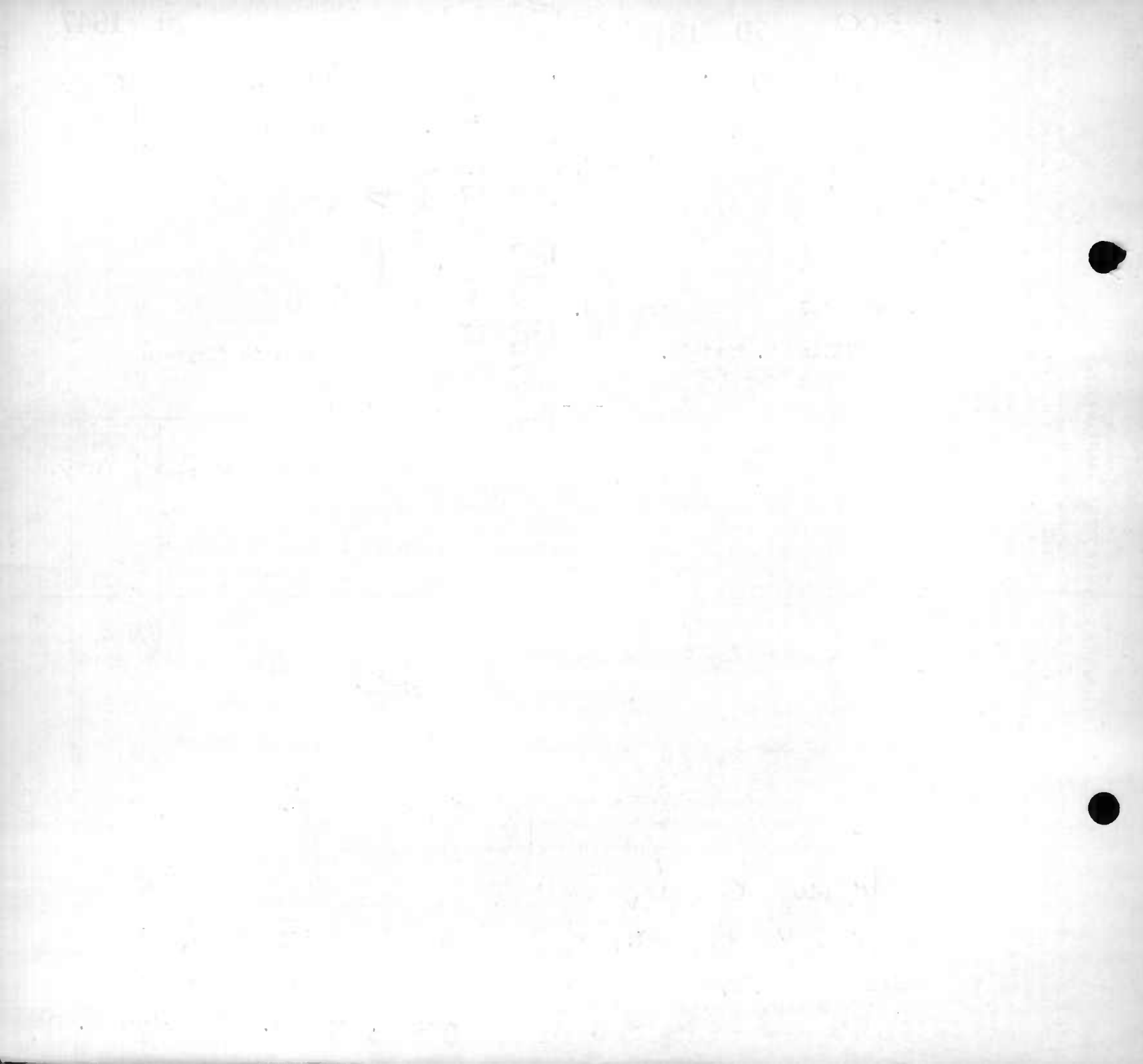
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1646	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JONES, SARAH N.		2/9/1970		10:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
UNION MEMORIAL HOSPITAL			MARYLAND U.S.A. 2706		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2710 BEECHLAND AVENUE		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	11/7/1891	47 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED-SEAMSTRESS				N. CAROLINA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
SIR WILLIAM JOHNSON			MARTH (UNKNOWN)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-05-9051-A		CLARENCE J. JONES 196 Kingston Rd. 21220	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			Myocarditis, acute		
			Hypertension - Gangrene right leg		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2/9				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2/8 1970 to 2/9 1970, that (I) (we) lost saw the deceased alive on 10:20 P.M. 2/9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Kasuke Tsujimoto, M.D.				2/9/1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
KASUKE TSUJIMOTO, M.D.				UNION MEMORIAL HOSPITAL 33RD AND CALVERT STS. BALTIMORE MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		2/13/70		PARKWOOD CEMETERY	
				BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 11 1970		Robert E. Fisher		LEONARD J. JUCK, INC. BALTO. MD. 21214	

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-300		70 1647		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1647	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) William D. Pitt Jr.			
2. DATE AND HOUR OF DEATH 2/9/70 1:00 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO				5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 3/3/19 9. AGE (In years lost birthday) 50 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEM. HOSP BALTO, MD.				CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 613 BARTLET AVE.				10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal 10B. KIND OF BUSINESS OR INDUSTRY Martin Co. 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William D. Pitt Sr.				14. MOTHER'S MAIDEN NAME Henrietta Slaysman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-16-8308		17. INFORMANT CHART ADDRESS	
18. 432.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CHF, PNEUMONIA				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (m.m.)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/8 2/10 19 70 to 2/8 19 70 that (I) (we) lost saw the deceased alive on 2/8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harry B. Sher MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) HARRY B. SHER				23D. ADDRESS UNION MEM. HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/12/70		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS 5305 Harford Rd. 21211	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

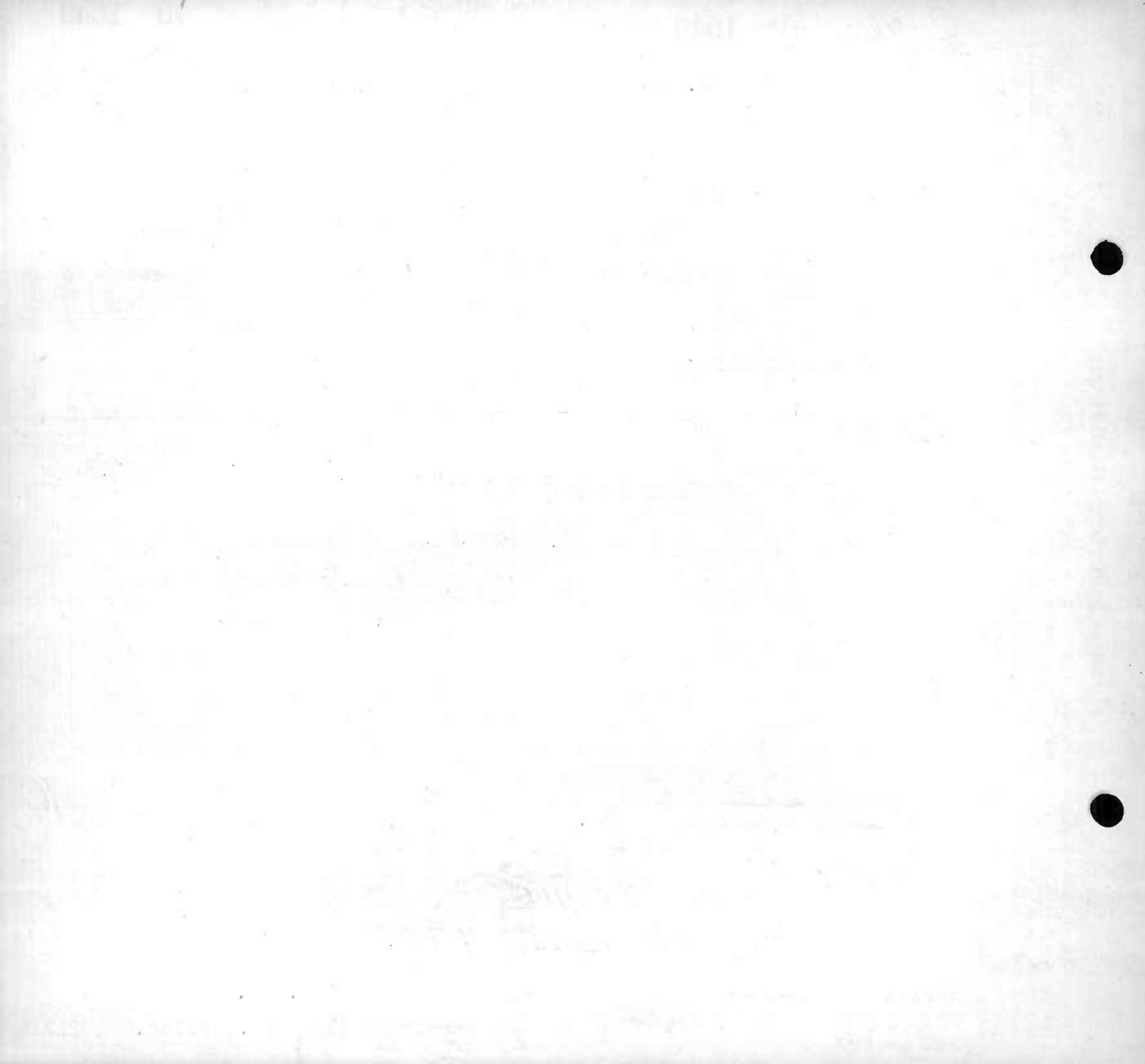
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
7-512		70 1648		70 1648	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Rachel Charlotte Thompson	
2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
2/8/70		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2235 Kentucky Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 6, 1912	9. AGE (In years last birthday) 57 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William S. Smith		14. MOTHER'S MAIDEN NAME R. Charlotte Hoffman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-24-9069		17. INFORMANT Mr. Frederick J. Thompson	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH ARTERIOSCLEROTIC HEART DISEASE (A) DUE TO (B) Diabetes mellitus (C) Old myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 7 yrs. 35 yrs. 2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from February 19 51 to February 8, 19 70, that (I) (we) last saw the deceased alive on February 2, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Lloyd E. Saylor		23B. DATE SIGNED Feb. 10, 1970		23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor	
23D. ADDRESS 3902 Greenmount Avenue		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 2/11/70.		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert J. Saylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

Joseph P. Taylor

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

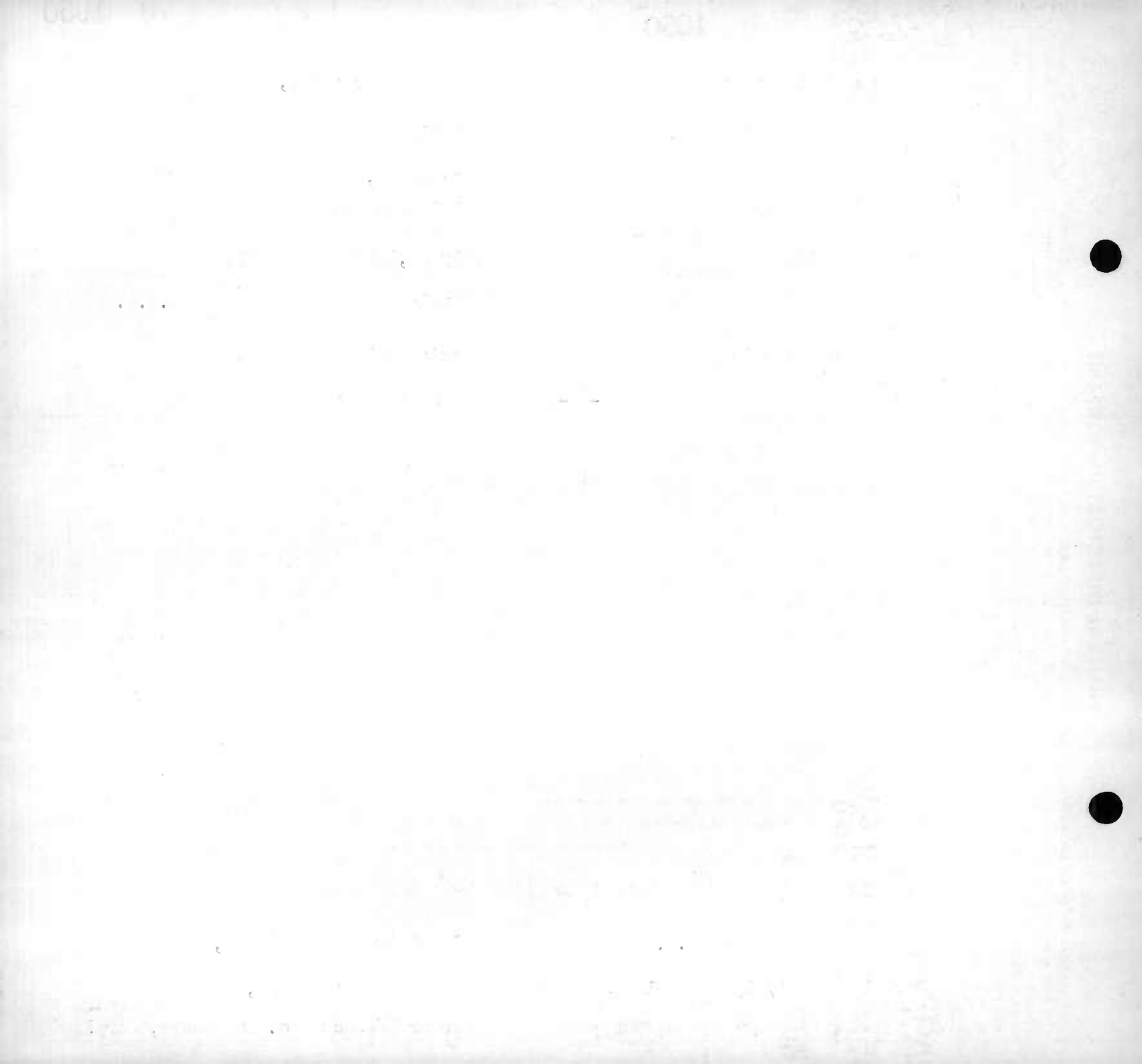
BIRTH NO. C-462 '70 1649				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1649	
1. NAME OF DECEASED (Type or Print) BERNARD J. CLARKE				2. DATE AND HOUR OF DEATH February 7, 1970 7:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 98 Gould Convalesarium				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 906			
5. SEX Male				6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH July 27, 1893				9. AGE (In years lost birthday) 76		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Michael Joseph Clarke			
14. MOTHER'S MAIDEN NAME Anna Hessey				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1			
16. SOCIAL SECURITY NO. 212-16-0126				17. INFORMANT A Miss Mary J Clarke 3527 Ailsa Ave 21214			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis Sudden ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary sclerosis Atherosclerotic C-V disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 10 1967 to Feb. 7 1970 , that (I) (we) last saw the deceased alive on Feb. 6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE H.V. Harbold MD				23B. DATE SIGNED 2/10/70			
23C. PHYSICIAN'S NAME (Type) H.V. HARBOLD MD				23D. ADDRESS 4706 Harford Road 21214			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2-10-70		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Leonard J. Hick Inc.		ADDRESS Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

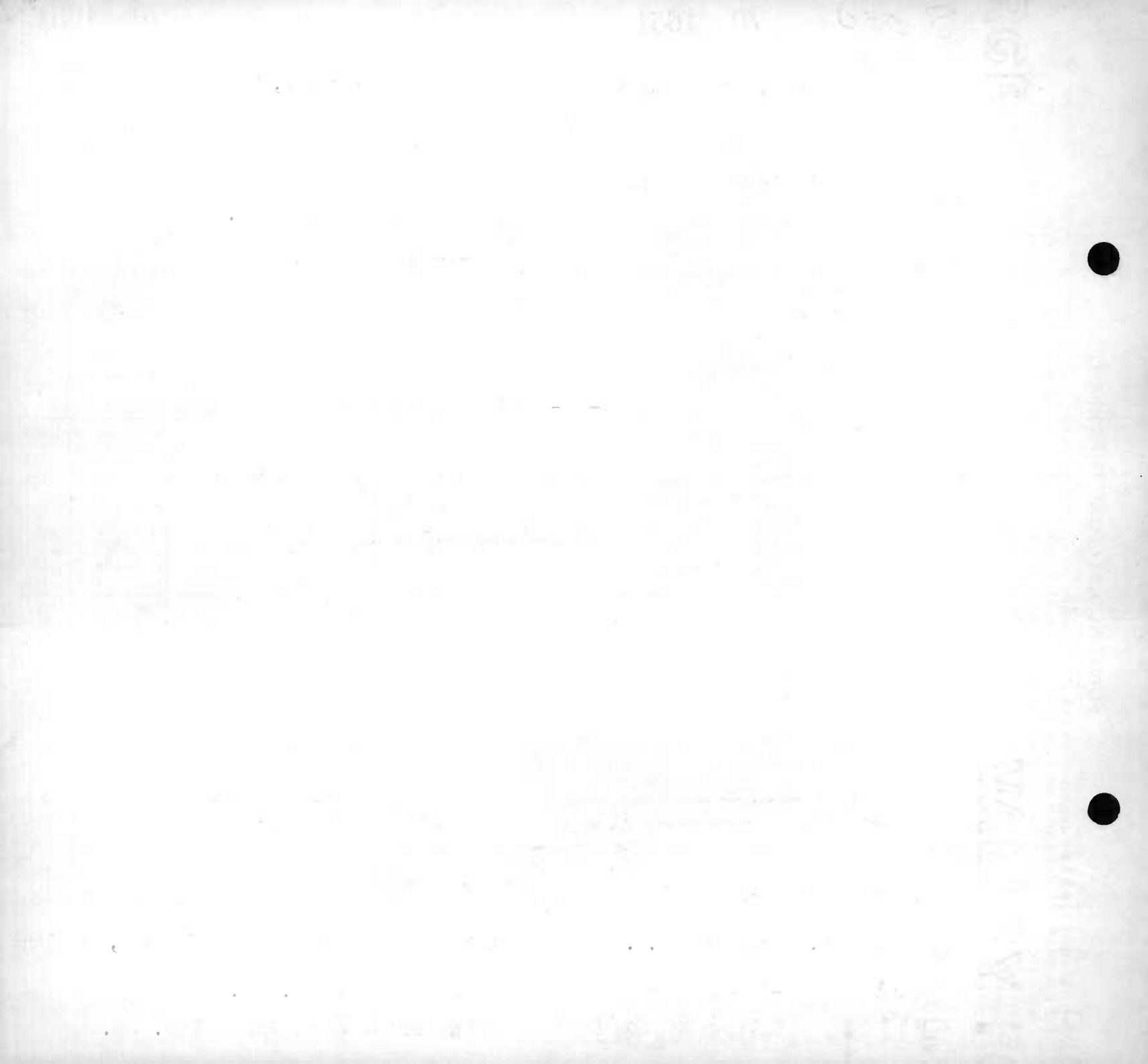
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
D-120 70 1650		70 1650			
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Anna Marie Davis			2. DATE AND HOUR OF DEATH February 7, 1970 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2632		
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
00		5303 Nuth Ave		E. STREET AND NUMBER 5303 Nuth Ave	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1896	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Hochrein		14. MOTHER'S MAIDEN NAME Lucia Heil		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-9123		17. INFORMANT ADDRESS Mr Martin I Davis Same	
18. 1970-8-14-250-9 CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cancer of the Prostate			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Diabetes Mellitus		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mario E. Comas M.D.				23B. DATE SIGNED 2-9-70	
23C. PHYSICIAN'S NAME (Type) Mario E Comas M.D.				23D. ADDRESS 6801 Belair Rd Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/11/70		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. STATE Maryland		24F. COUNTY Baltimore	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

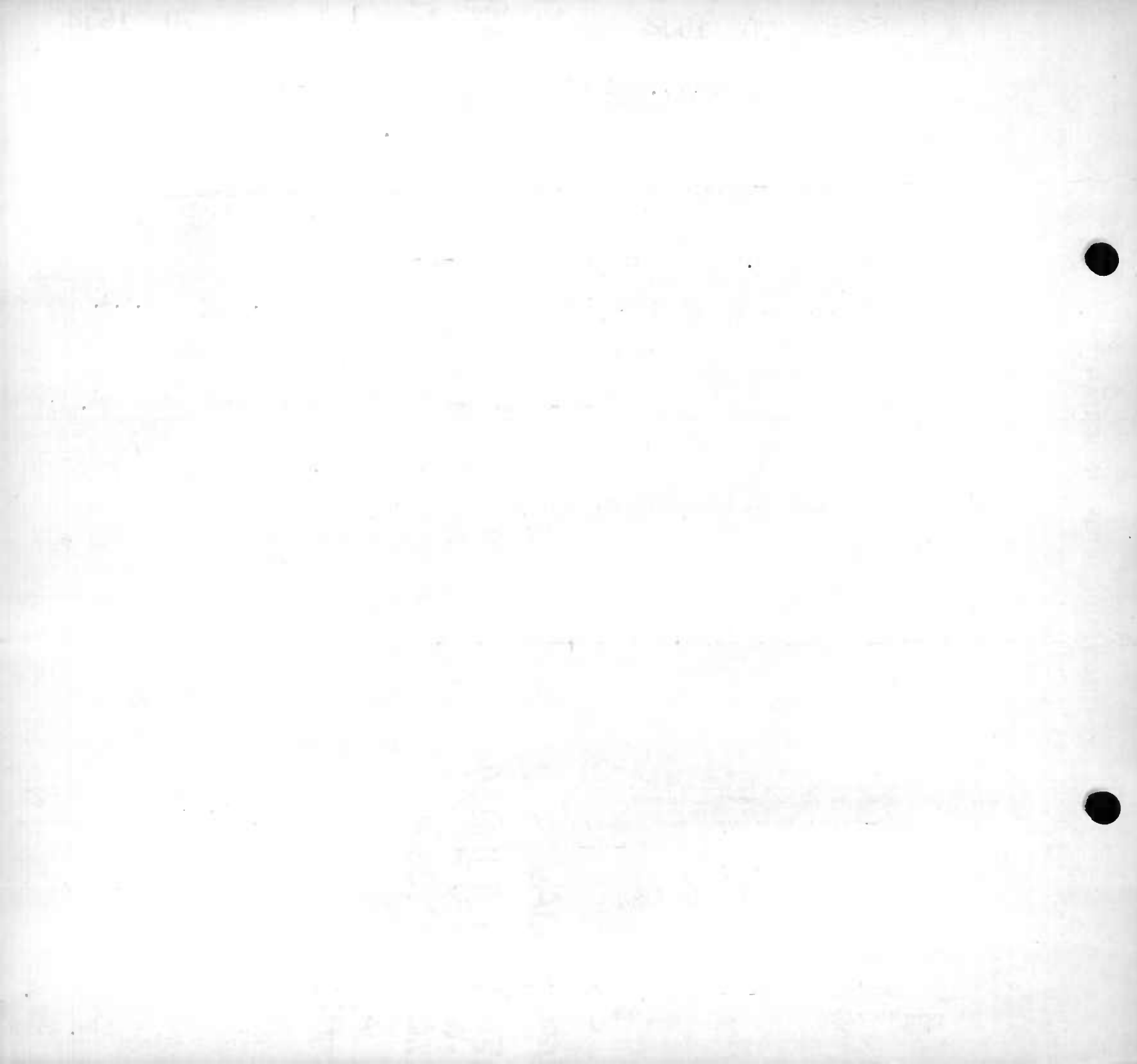
Baltimore City Health Department				REG. NO.		70 1651	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Margaret Schmitt</u>				2. DATE AND HOUR OF DEATH <u>February 7, 1970</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Gould Convalesarium</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2741</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Cedarhurst Rd.</u>			
5. SEX F <input checked="" type="checkbox"/> W <input type="checkbox"/>		6. RACE W <input checked="" type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-1878</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Worked</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sebastian Schmitt</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Zech</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-50-9969</u>		17. INFORMANT ADDRESS <u>21214</u> <u>Mrs Anthony J Boglia 3506 Ailsa Ave</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Artery Disease</u> (B) <u>Anterolateral C.V.D.</u> (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>Feb 7</u> 1970 , that (I) (we) last saw the deceased alive on <u>Feb 7</u> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. Henry Haase M.D.</u>				23B. DATE SIGNED <u>Feb 10, 1970</u>		23C. PHYSICIAN'S NAME (Type) _____	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>2-10-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Most Holy Redeemer</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>FEB 11 1970</u>			
25B. NAME OF REGISTRAR <u>Leonard J. Ruck</u>				25C. FUNERAL DIRECTOR <u>Inc Balto. Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1652	
<div style="display: flex; justify-content: space-between;"> C-543 70 1652 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mattie L. Chinault		2-7-1970 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial			A. STATE Md.		
			B. COUNTY 2633		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3442 Erdman Avenue 21213		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Cau.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9-13-1883	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Housewife		Bowling Green Va.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Bruce			Rosina Brooks		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-18-4341D		Mrs Lois Scarborough 3442 Erdman Ave. 2;2	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Coronary Thrombosis due to		
			(B) Advanced Generalized Arteriosclerosis		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/14 1949 to 2/7 1970, that (I) (we) last saw the deceased alive on 1/19 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
L B Stevens				2/10/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2-10-70		Moreland Park Cemetery	
				Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 11 1970		E. J. [unclear]		Gassan Funeral Home 7401 Belair Rd. 21236	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
70 1653		70 1653		70 1653	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>L-140</u> CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>Evelyn Marie Lovell</u>			2. DATE AND HOUR OF DEATH <u>2-7-1970</u> <u>2:30A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>5921 Burgess Avenue</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2744</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>5921 Burgess Avenue 21214</u>		
5. SEX <u>Female</u>	6. RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-1884</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Augustus Cohrt</u>			14. MOTHER'S MAIDEN NAME <u>Mamie Vetumski</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-05-2122D</u>		
			17. INFORMANT <u>Henry Lovell</u> ADDRESS <u>3423 Woodring Avenue 2123</u>		
18. <u>437.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral arteriosclerosis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 7, 1969</u> to <u>Feb 7, 1970</u> , that (I) <u>last</u> saw the deceased alive on <u>Dec 10, 1969</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald Wandert</u>				23B. DATE SIGNED <u>2-7-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>R Donald Wandert</u>				23D. ADDRESS <u>7403 Hanford Rd</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2-10-1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Park Cem.</u>	
24D. LOCATION <u>Baltimore</u>		24E. (City, town, or county) (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 11 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Clasahn Funeral Home</u>	
				ADDRESS <u>7401 Delair Road</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 1654					REG. NO. 70 1654				
BIRTH NO. <u>H-460</u>					1. NAME OF DECEASED (Type or Print) <u>HELEN HELLER</u>				
2. DATE AND HOUR OF DEATH <u>2-7-70</u> <u>6²⁹</u> P.M.					3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>604</u>					5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General</u>				
6. CITY OR TOWN <u>BALTIMORE</u>					7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
8. STREET AND NUMBER <u>1905 Mc ELDERBY ST</u>					9. SEX <u>F</u> 10. RACE <u>WHITE</u>				
11. DATE OF BIRTH <u>9-30-04</u> 12. AGE (In years last birthday) <u>65</u>					13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
14. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>					15. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
16. FATHER'S NAME <u>DAVID HELLER</u>					17. MOTHER'S MAIDEN NAME <u>ANNA C. SCHMIDT</u>				
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					19. SOCIAL SECURITY NO. <u>712-05-1631</u>				
20. INFORMANT <u>MRS AMANDA HICKMAN</u>					21. ADDRESS <u>1915 Mc ELDERBY</u>				
22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction - extensive</u>					23. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Wks -</u>				
24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Severe Coronary atherosclerosis</u>					25. (B) DUE TO, OR AS A CONSEQUENCE OF: <u></u>				
26. (C) <u></u>					27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u></u>				
II									
28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u></u>									
29. DATE OF OPERATION <u>None</u>					30. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>				
31. AUTOPSY? (Yes or No) <u>Yes</u>					32. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>				
33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>				
35. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u></u>					36. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
37. HOW DID INJURY OCCUR? <u></u>					38. I certify that (I) (this hospital) attended the deceased from <u>1/13</u> 19 <u>70</u> to <u>2/7</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
39. SIGNATURE <u>Louis E. Gruyer M.D.</u>					40. DATE SIGNED <u>2/7/70</u>				
41. PHYSICIAN'S NAME (Type) <u></u>					42. ADDRESS <u></u>				
43. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					44. DATE <u>2/11/70</u>				
45. NAME of CEMETERY or CREMATORY <u>BALTIMORE CEMETERY</u>					46. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>				
47. DATE REC'D BY HEALTH DEPT. <u>FEB 11 1970</u>					48. NAME OF REGISTRAR <u>Robert E. Taylor</u>				
49. FUNERAL DIRECTOR <u>VERLICH FEDERAL HOME, BALTO, MD</u>					50. ADDRESS <u>21206</u>				

X P-30-04 22

F

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 1655	
BIRTH NO. K-000		70 1655		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Key, Robert (Keys)			2. DATE AND HOUR OF DEATH 2-9-70 1 8:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE MD B. COUNTY 1402		
FULL NAME OF HOSPITAL OR INSTITUTION Key Circle Hospice 1214 Eutam Place		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN Balto.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1619 DRUID HILL AVE.					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-3-96	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salina, Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-03-8889		17. INFORMANT Robert Keys 1707 W. Engelle St.	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Circulatory failure (B) Atherosclerotic CVD (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 5 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-25 1969 to 2-9 70 that (I) (we) last saw the deceased alive on 2-5 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard R. Rigler		23B. DATE SIGNED 2-9-70		23C. PHYSICIAN'S NAME (Type) RICHARD R. RIGLER	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2/16/70		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert Keys		25C. FUNERAL DIRECTOR E. H. Carroll 1712 W. North Ave	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1656	
BIRTH NO. H-252		70 1656	
1. NAME OF DECEASED (Type or Print) <u>Haskins, Foster Alexander</u>		2. DATE AND HOUR OF DEATH <u>11-8-70</u> <u>2-8-1970</u> M. <u>15</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>2-19-70</u> <u>US Public Health Service Hosp.</u> <u>Wyman Park Dr Baltimore</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4616 Kavan Ave</u>	
5. SEX <u>M</u>	6. RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/13</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher - Bus Co</u>		9. AGE (In years last birthday) <u>56</u>	11. BIRTHPLACE (State or foreign country) <u>Maine</u>
10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Haskins</u>		14. MOTHER'S MAIDEN NAME <u>Josephine McCorison</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>USA</u> <u>1937-1946</u>		16. SOCIAL SECURITY NO. <u>216-26-7931</u>	17. INFORMANT <u>Chart</u>
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u> <u>hrs.</u>	
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>—</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>1/7/70</u> 19 to <u>2/8/70</u> 19 that (I) (we) last saw the deceased alive on <u>1/8/70</u> <u>2-8-1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Peter J. Philpott MD</u>		23B. DATE SIGNED <u>2-8-70</u> <u>11-8-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Peter J. Philpott MD</u>		23D. ADDRESS <u>USPHS Hosp. Balt.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>2/11/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 11 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Walker, M.D.</u>	25C. FUNERAL DIRECTOR <u>WORTH FUNERAL HOME 4210 BEAULIE RD</u>	

Letter from U.S.P.H.S.

2-19-70

M.H.

FUNERAL DIRECTOR: IMPORTANT

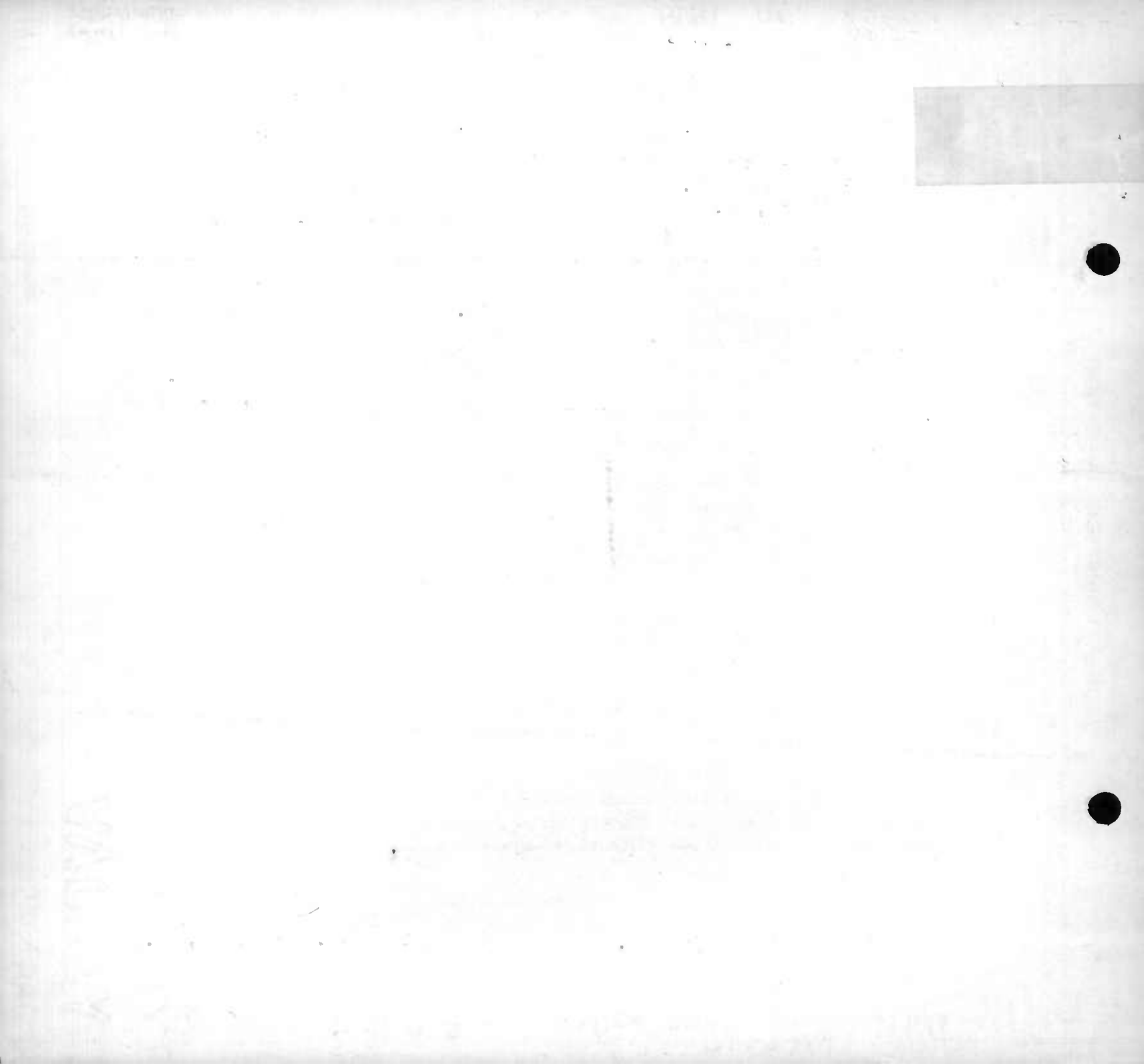
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-240 70 1657		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 1657	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) VOGEL, EMMA ESTELLE				FEBRUARY 9, 1970 1:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL 2-16-70				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 212345310			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 19, 1896 01/15/1896	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 74 73		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM LEYSHON				14. MOTHER'S MAIDEN NAME ROSETTA KIRKWOOD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT BALTIMORE, MARYLAND 21229 ST AGNES' RECORDS CATON & WILKENS AVES			
18. 18291 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CA of uterus & vulva				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) CA of uterus & vulva			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>II</u> (this hospital) attended the deceased from <u>DECEMBER 16</u> 19 <u>69</u> to <u>FEBRUARY 9</u> 19 <u>70</u> that <u>I</u> (we) last saw the deceased alive on <u>FEBRUARY 9</u> 19 <u>70</u> and that <u>in</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>I</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE Adolfo Alonso M.D.				23B. DATE SIGNED 2/9/70		23C. PHYSICIAN'S NAME (Type) ADOLFO ALONSO	
23D. ADDRESS ST AGNES HOSP WILKENS & CATON BALTO MD 21229				23E. FUNERAL DIRECTOR'S ADDRESS Ulrich Funeral Home Dundalk, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/11/70		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR'S ADDRESS Ulrich Funeral Home Dundalk, Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 1-360 70 1658				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		REG. NO. 70 1658	
1. NAME OF DECEASED (Type or Print) <i>Edgar Lyter</i>				2. DATE AND HOUR OF DEATH <i>February 8, 1970, 09:00 P.M.</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospitals</i> ADDRESS OR LOCATION <i>4940 Eastern Ave. Baltimore, Md. 21224</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Dundalk</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>1918 Maxwell Ave. 21222 005</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-31-91</i>		9. AGE (In years last birthday) <i>78</i>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Lyter</i>				14. MOTHER'S MAIDEN NAME <i>Lizzie Crombrigh</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>212-01-9262</i>		17. INFORMANT <i>4940 Eastern Ave. ADDRESS Baltimore, Md. 21224</i> BCH Records:			
18. <i>E8851X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.				CAUSE OF DEATH <i>cardiorespiratory arrest</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Renal Failure</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Fracture of Q Hips</i> (C) <i>CNS (treated)</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>acute</i> <i>years</i> <i>years</i> <i>years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home (2)</i>		21C. WHERE DID INJURY OCCUR? <i>1918 Maxwell Ave 53-00</i>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <i>9-69 AM</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>slipped & fell after getting up from chair</i>					
22. I certify that (I) (this hospital) attended the deceased from <i>November 5, 1969</i> to <i>February 8, 1970</i> , that (I) (we) last saw the deceased alive on <i>February 8, 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Francisco Tejada, M.D.</i>				23B. DATE SIGNED <i>Feb 8, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>Francisco Tejada Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/11/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Colgate, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 11 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Ulrich Funeral Home</i>		25D. ADDRESS <i>Dundalk, Md.</i>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1659

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEE WILLIAM BROWN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour February 9, 1970 5:00 P.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2716			
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 12-19-1960		10. AGE (In years last birthday) 9	E. STREET AND NUMBER 3032 Rosaland Avenue
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME WILLIAM BROWN
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME NANCY SULLIVAN
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. NONE	18. INFORMANT ADDRESS NANCY LOGAN 3032 ROSALAND AVE
19. E814.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Multiple Traumatic Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME OF INJURY (APPROX.) 2-1-70 2:45 P.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Pimlico Rd. 14' N. of Rosaland Avenue	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by car	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/11/70 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) TRANSIT-BURIAL		24B. DATE 2/14/1970	
24C. NAME OF CEMETERY or CREMATORY VIOLET HILL CEM.		24D. LOCATION (City, town, or county) (State) EMMA, N.C.	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Marshall Jones, 1735 HARFORD AVE	
25C. FUNERAL DIRECTOR		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-625		70 1660		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 1660	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) JOHN P. KRAWCZYNSKI			
2. DATE AND HOUR OF DEATH 5-9-70 1:55 AM.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 Mercy Hospital			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 105				5. CITY OR TOWN Baltimore			
6. STREET AND NUMBER 320 S. Patterson Park Ave.				7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-14-92	
9. AGE (in years, last birthday) 77		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Barber				10B. KIND OF BUSINESS OR INDUSTRY Self-employed			
13. FATHER'S NAME George Krawczynski				14. MOTHER'S MAIDEN NAME Josephine Nowacki			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-3757		17. INFORMANT Mrs. Katherine Krawczynski, Patterson Pk.			
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrhythmia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ASGVD DUE TO, OR AS A CONSEQUENCE OF: years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 2/5 1970 to 2/9 1970 that (we) last saw the deceased alive on 2/9 1970 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
23A. SIGNATURE Barredo MD				23B. DATE SIGNED 2/9/70		23C. PHYSICIAN'S NAME (Type) BARBEDO MD	
23D. ADDRESS MERCY HOSP							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/13/70		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 11 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR M. F. SADOWSKI & SONS, 1808 EASTERN AVE			

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1661

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANCES TRAWINSKI

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Md.

B. COUNTY

201

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1/29/09

10. AGE (In years
last birthday)

59 61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

415 S. Chapel St.

11. BIRTHPLACE (State or foreign country)

Mississippi

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Trawinski

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machine Operator

14B. KIND OF BUSINESS OR INDUSTRY

Metal Can Mfr.

15. MOTHER'S MAIDEN NAME

Josephine Sala

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

215-09-6185

18. INFORMANT

ADDRESS

Miss Julia Trawinski, 415 S. Chapel St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cranio-cerebral injuries
DUE TO, OR AS A CONSEQUENCE OF:DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

house

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1109 Foxwood Rd. Essex, Md.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

2-8-70

2:30 P.m.

22E. INJURY OCCURRED
WHILE AT WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject fell down steps.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-9-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/12/70

24C. NAME OF CEMETERY OR CREMATORY

Holy Rosary

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 11 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

M.F. SADOWSKI & SONS, 1808 EASTERN AVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| P-620 | | 70 1662 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 570 2 1662 | |
|--|------------------|---|------------------------------|---|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | | |
| | | | | GENEVA PIERCE | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH
January 31, 1970 11:20 A.M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY | | | |
| 33 Johns Hopkins Hospital | | | | MARYLAND
C. CITY OR TOWN
BALTIMORE
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER
1814 W. PRATT STREET | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
01-31-22 | 9. AGE (In years lost birthday)
47 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Barmaid | | | | James town, Tenn. | | USA | |
| 13. FATHER'S NAME
Presse Hood | | 14. MOTHER'S MAIDEN NAME
Elsie York | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
412-36-6774 | | 17. INFORMANT
Arthur. Pierce (1814 W Pratt St.) | | ADDRESS | |
| 18. 571.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
HEPATIC ENCEPHALOPATHY
(B) LAENHART'S CIRROSIS
(C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
5 years
5 days | |
| 19A. DATE OF OPERATION
JAN. 28, 1970 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
RESPIRATORY FAILURE | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from JAN. 27 1970 to JAN. 31 1970, that (1) (we) last saw the deceased alive on JAN. 31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Stephen C. Achuff M.D. | | | | 23B. DATE SIGNED
Jan. 31, 1970 | | | |
| 23C. PHYSICIAN'S NAME (Type)
STEPHEN C. ACHUFF M.D. | | | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
2/4/70 | | 24B. DATE
2/4/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Taylor Cemetery | | 24D. LOCATION (City, town, or county) (State)
Fentress Co., Tenn. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 11 1970 | | 25B. NAME OF REGISTRAR
Ruth E. Taylor | | 25C. FUNERAL DIRECTOR
Gail P. Fair | | ADDRESS
BALTO., MD. | |

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Handwritten text in the middle section, possibly a date or location.

Handwritten text in the middle section, possibly a name or subject.

Handwritten text in the middle section, possibly a name or subject.

Handwritten text in the middle section, possibly a date or location.

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Handwritten text at the bottom left, possibly a date or location.

Handwritten text at the bottom left, possibly a date or location.

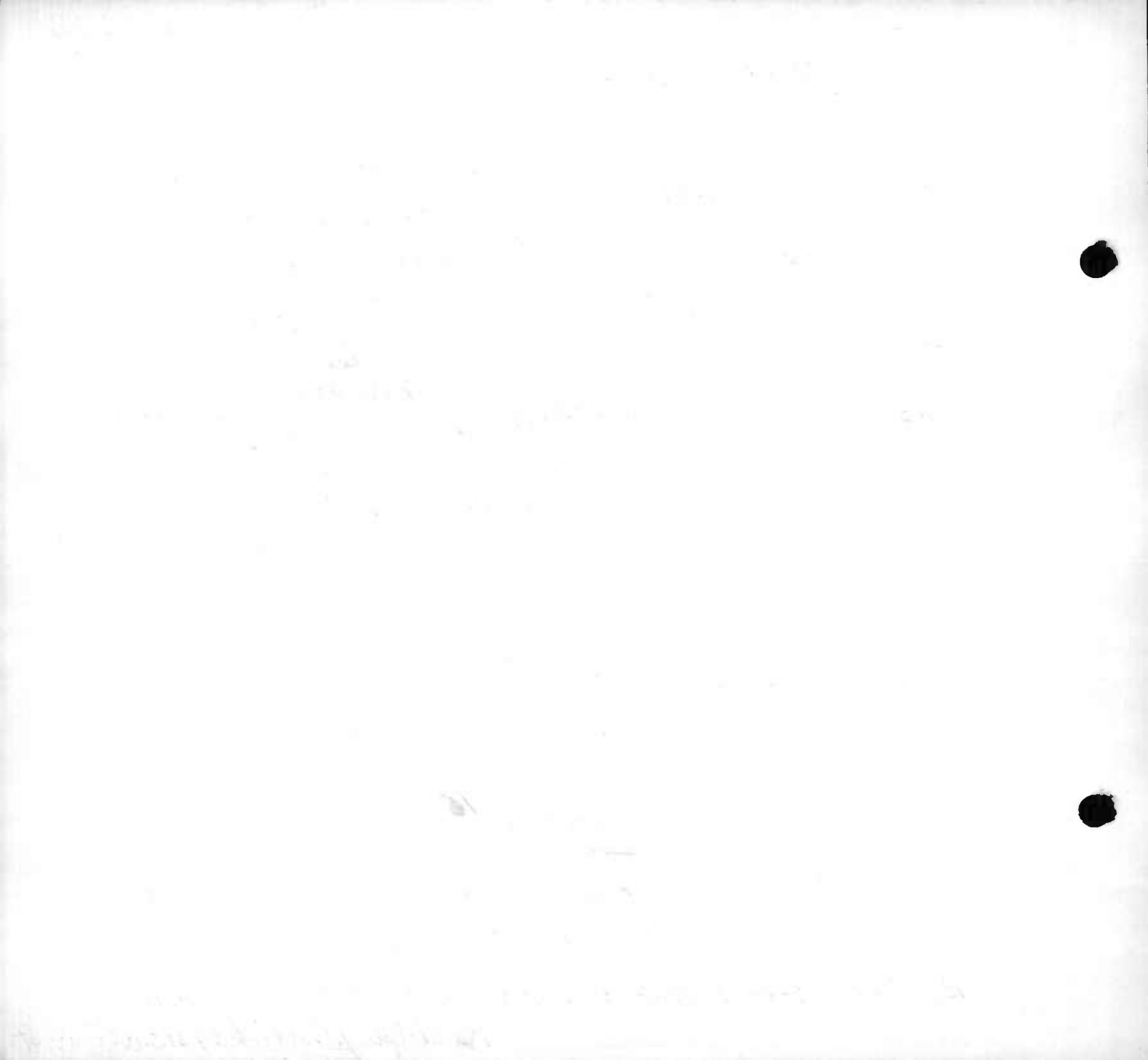
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Handwritten text at the bottom left, possibly a date or location.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-420 | | 70 1663 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | | 70 1663 | |
|--|---------------------|---|--|---|--|---|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) <i>OTHO M. BLACK</i> | | | | 2. DATE AND HOUR OF DEATH
<i>2/4/70 9:30 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>md.</i> B. COUNTY <i>843</i> | | | | C. CITY OR TOWN <i>Balt.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>May Hosp.</i> | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | E. STREET AND NUMBER
<i>2716 Beryl Ave. 21205</i> | |
| 5. SEX
<i>M</i> | 6. RACE
<i>N</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>3/27/17</i> | | 9. AGE (in years last birthday)
<i>52</i> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Brick worker</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Steel</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Balt. md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | |
| 13. FATHER'S NAME
<i>Arthur Black</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Sallie Jones</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | 16. SOCIAL SECURITY NO.
<i>213-19-2399</i> | | 17. INFORMANT <i>Miss Sallie Balling</i> ADDRESS <i>2716 Beryl Ave.</i> | | | |
| 18. I <i>73.6 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
<i>Bleeding</i>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>metastatic carcinoma to pelvis, groin, lungs.</i>
(B) <i>Epidermoid Ca of Anus</i>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 months</i>
<i>3 yrs.</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>1/25</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Exp. Sp. Ligature L. Throat</i> | | | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____ | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/18/70</i> 19__ to <i>2/4</i> 1970
that (I) (we) lost saw the deceased alive on <i>2/3/70</i> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Wm. B. Reever Jr. M.D.</i> | | | | 23B. DATE SIGNED
<i>2/4/70</i> | | | | 23C. PHYSICIAN'S NAME (Type)
<i>Wm. B. REEVER JR., M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME of CEMETERY or CREMATORY | |
| <i>Burial</i> | | | | <i>2-8-70</i> | | | | <i>Arbutus Memorial Pk. Arbutus, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 11 1970</i> | | | | 25B. NAME OF REGISTRAR
<i>Robert C. Taylor</i> | | | | 25C. FUNERAL DIRECTOR
<i>Randolph J. Collick</i> | |
| | | | | | | | | ADDRESS
<i>2431 E. Oliver St.</i> | |



D-650

70

1664

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1664

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHRISTOPHER DERRIEN

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

LUTHERAN HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

12:45 P.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

1509

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

July 15 62

10. AGE (In years
last birthday)

7

If Under 1 Yr. II Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3835 Clifton Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Sherdave Derrien

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

3835 Clifton Avenue

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

3835 Clifton Avenue

19.

E 9121

CAUSE OF DEATH

Asphyxia due to Aspiration of Toy Ballon

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3835 Clifton Avenue 1509

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

2-10-70

P.M.

22E. INJURY OCCURRED
WHILE AT WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject choked on ballon

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2/11/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE RECEIVED BY HEALTH

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

ACADEMY OF ARTS

ADMISSION

EXHIBITION

1985

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1665 | |
|--|----------------------|---|------------------------------------|---|---|
| 70 1665 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) MAMIE H. MILLER | | 2. DATE AND HOUR OF DEATH
2-8-70 1:30 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE MD.
B. COUNTY 1605 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
46 LUTHERAN HOSPITAL OF MD. | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
2309 WINCHESTER ST. | | | |
| 5. SEX
F. | 6. RACE
N. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-10-04 | 9. AGE (In years lost birthday)
65 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
VA. | |
| 13. FATHER'S NAME
Willie Martin | | 14. MOTHER'S MAIDEN NAME
Emma Snow Fowlkes | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-07-6821 | | 17. INFORMANT
Horace E. Miller 2309 Winchester Street | |
| 18. 436.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Cerebro-vascular accident. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Cerebro-vascular accident. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-27 19 69 to 2-8 19 70 , that (I) (we) last saw the deceased alive on 2-8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Violet R. Bamauer | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
VIOLET R. BAMAUER R. M.D. | | | | 23D. ADDRESS
730 Ashburton St. Baltimore Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/12/70 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Memorial Park | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. LOCATION (City, town, or county) | | 24F. LOCATION (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 11 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Phillips Funeral Home 1727 N. Monmouth | |
| 25D. ADDRESS | | 25E. ADDRESS | | 25F. ADDRESS | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1666 | |
|--|------------------|--|---|--|---|
| 70 1666 | | | | 70 1666 | |
| CERTIFICATE OF DEATH | | | | REG. NO. | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Johnson, George R. | | 2-6-70 1:35 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

39
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Provident Hospital
1514 Divison Street
Baltimore, Maryland 21217 | | | A. STATE
Maryland | | |
| | | | B. COUNTY | | |
| | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
1510 N. Payson Street | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-25-97 | 9. AGE (In years last birthday)
72 | 10. Under 1 Yr. Months Days
11 Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired-Dept. Of Education | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
Unknown | | | 14. MOTHER'S MAIDEN NAME
Lauvinia ? | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-18-9343 | | 17. INFORMANT
Mrs. Mary E. Johnson-wife | |
| | | | | ADDRESS
Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.)

492X I
CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Emphysema Severe</i>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-3-70 19 to 2-6-70 19 that (I) (we) last saw the deceased alive on 2-6-70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Phareds</i> | | | | 23B. DATE SIGNED
Feb. 6, 1970 | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Phareds</i> | | | | 23D. ADDRESS
1514 Divison Street Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/9/70 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Memorial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 11 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Arrington S. Phillips | |
| | | | | ADDRESS
1727 N. Monroe Street | |

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1971-1972

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|--|---|--|---|--|
| 70 1667 | | 70 1667 | | 70 1667 | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | M. | |
| NICHOLAS - MARY - ALICE | | 2/6/70 1:30 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 425 Sinai Hospital, Baltimore, MD.
21215- | | city - Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| F | | N | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| maid | | housewife at Permethic | | 2/10/21 | |
| 11. BIRTHPLACE (State or foreign country) | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| North Carolina | | 48 | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| American | | Frank H edgepeth | | Vennia Allen | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 243-32-1629 | | Clifford Nicholas 2507 Quantico Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| I (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE | | 13 Hours | |
| ANTECEDENT CAUSES | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ASCAVD - hypertension | | at least 2 years | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | ASCVD - Late latent Leues (Treated until 1968) | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-6-70 1970 to 2-6 1970 | | that (I) (we) last saw the deceased alive on 1 PM 2-6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| R. Hoorazar, M.D. | | 2-6-70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| R. HOORAZAR, M.D. | | Sinai Hospital, Baltimore - MD. 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Removal | | 2/9/70 | | Mount Calvary Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 11 1970 | | Robert E. Taylor, M.D. | | Bahama, North Carolina | |
| VS 150-REV. 1/1/68 | | | | 83 Phillips 1727 N. Monroe Street | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1668

REG. NO.

VS 151-REV. 7/1/68

N 870 870 000 000 000 000

1931

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WORLD BANK

1931

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1931

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ACADEMY

1931

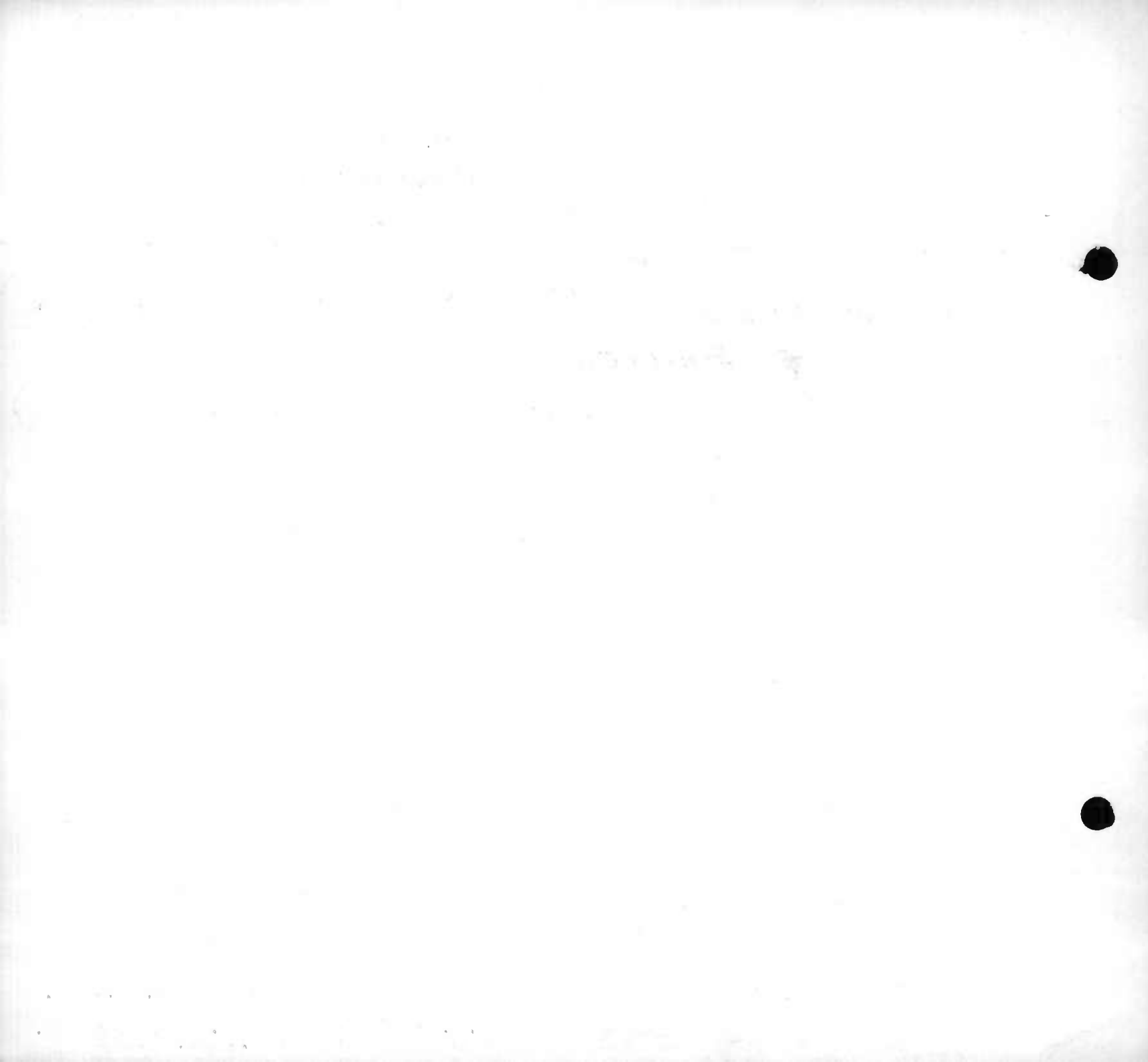
1

1931

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

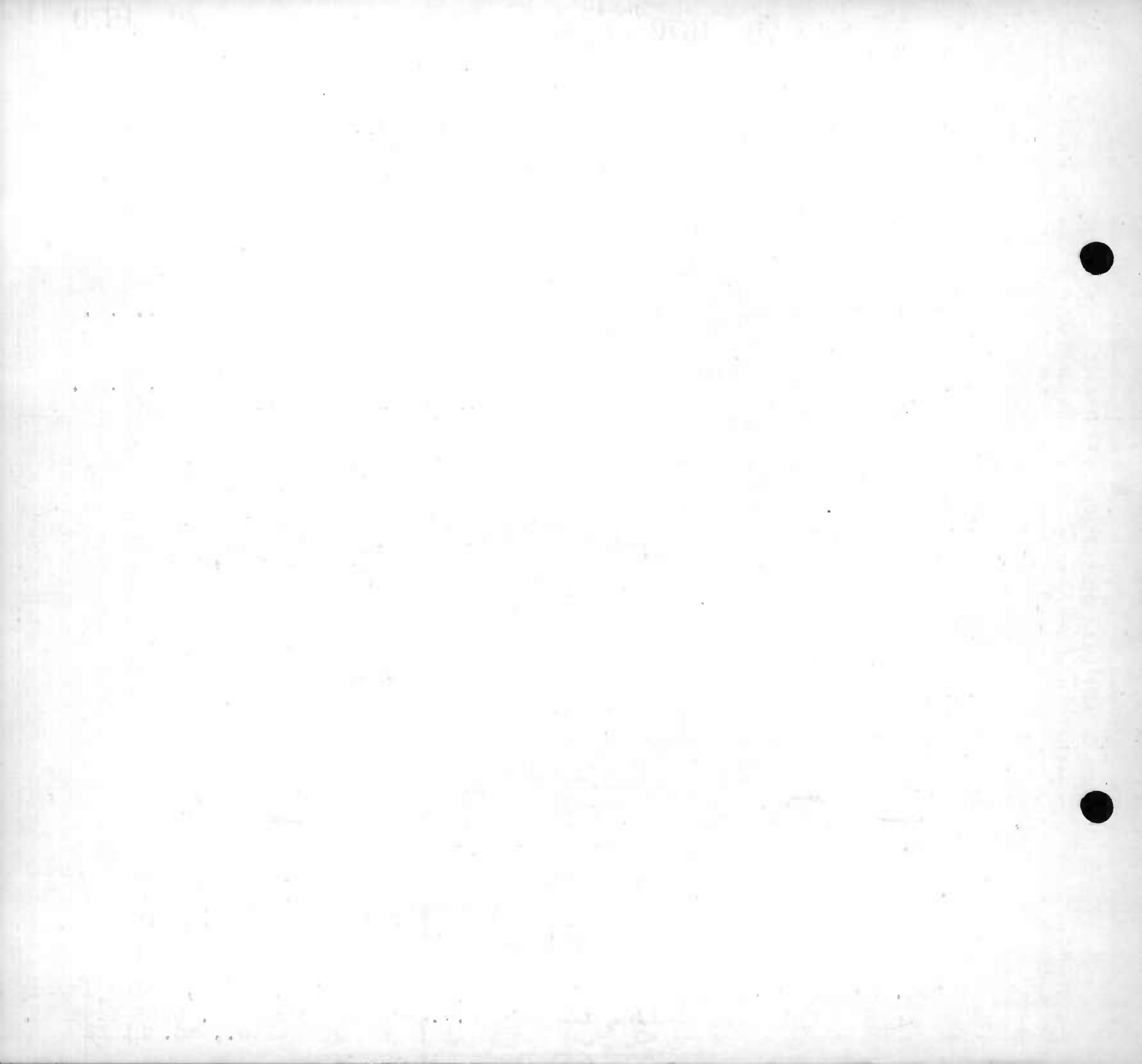
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|---|---------|--|------------------|--|--------------------------------|
| 70 1669 | | 70 1669 | | 70 1669 | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| BAUER, Mrs. ESTHER M. | | 2-9-70 2:05 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| 48 Maryland General Hospital | | MARYLAND | | | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 300 W. Coldspring Lane | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE in years last birthday | 10. If Under 1 Yr. Months Days |
| F. | W | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 4-24-98 | 71 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETIRED HOMEMAKER | | OWN HOME | | BALTIMORE, MD. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| S. HILLEN | | Unknown | | U.S.A. | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 219-28-7290 | | (Son) Peter Harry Bauer (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from 2-8-70 to 2-9-70 that (I) lost saw the deceased alive on 2-9-70 and that (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| J. S. Kim | | 29/1970 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| J. S. Kim M.D. | | Maryland General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 2/11/70 | | Parkwood | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Parkville, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 11 1970 | | Robert E. Fisher, M.D. | | H.W. Jenkins & Sons Co., 1905 York Rd. Balto., Md. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

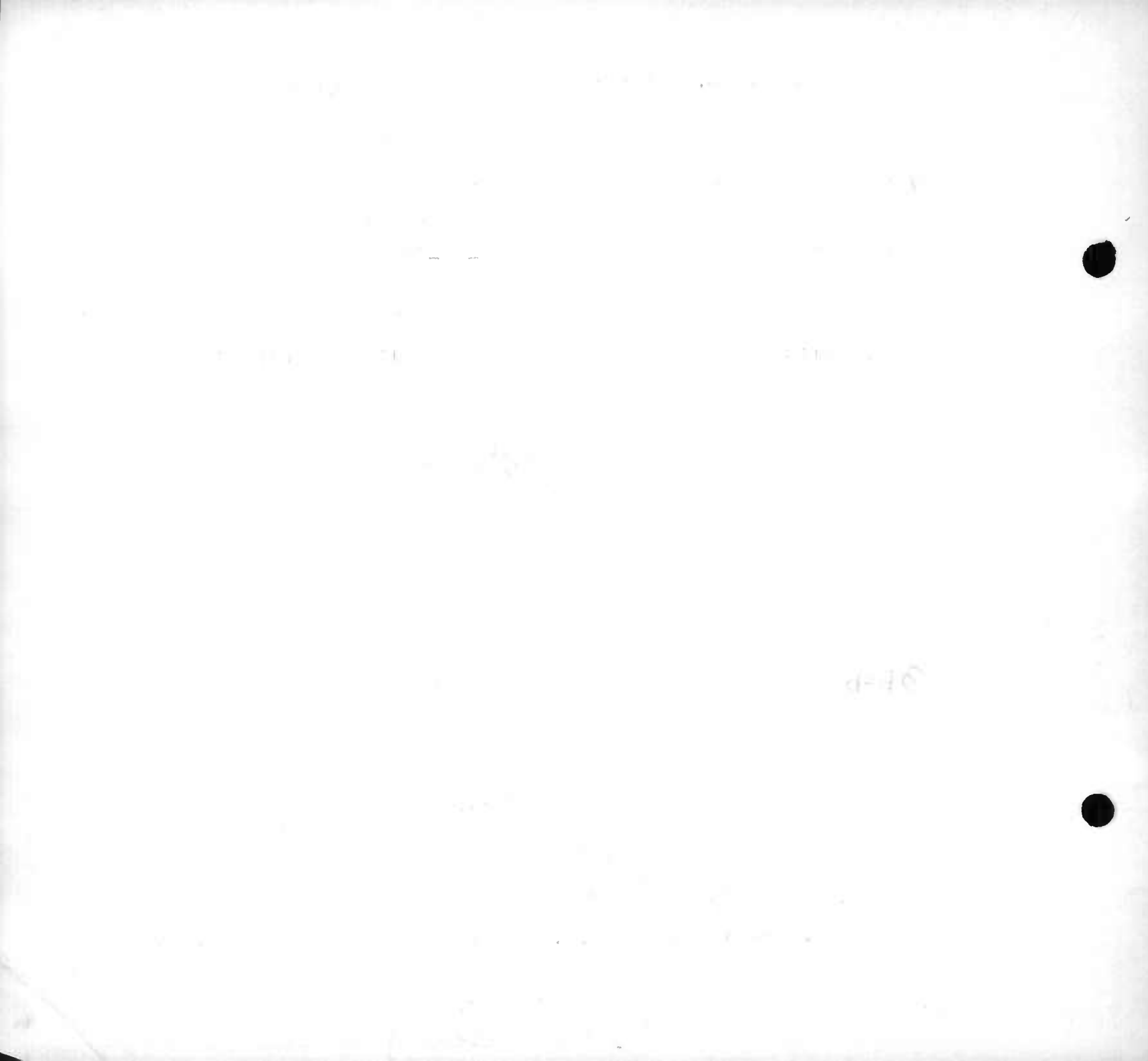
| BALTIMORE CITY HEALTH DEPARTMENT | | 70 1670 | | CERTIFICATE OF DEATH | | REG. NO. 70 1670 | |
|---|---------|---|------------------|---|---------------------------------|--|------------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | FRANCES JULIAN | | 10 Feb 1970 | | 2:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | | |
| | | | | New Jersey | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 33 The Johns Hopkins Hospital | | | | Northfield | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 134 Bonnie Lee Drive | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days | If Under 24 Hrs. Hours: Min. |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 2/18/98 | | 71 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | Own Home | | New York | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Joseph Valentini | | | | Adelaide Vitelli | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | Atlantic City, N. J.
Jeffries-Keates Funeral Home | | | |
| 18. 486X I | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | ? Pulmonary Emboli | | | | 3 Hrs | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ANTECEDENT CAUSES | | (B) Chronic pneumonia CHF G.I. bleed 2 wks | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | (C) thrombocytopenia | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| O | | | | NO Removal | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Feb 1 1970 to Feb 10 1970, that (2) (we) last saw the deceased alive on Feb 9 1970 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| James E. Muller | | | | 10 Feb 1970 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| JAMES MULLER | | | | 1531 E. Monument St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Rem. Burial | | 2/13/70 | | Holy Cross | | May's Landing, New Jersey | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 11 1970 | | Robert E. Jenkins, Jr. | | H.W. Jenkins & Sons Co. | | 4905 York Rd. Balto., Md. 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1671</u> | |
|--|--|--|---|---|---|
| BIRTH NO. <u>C-140</u> | | 70 1671 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>MARY C. CABBELL</u> | | | 2. DATE AND HOUR OF DEATH
<u>2-5-70</u> <u>2:00 P</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>THE JOHNS HOPKINS HOSPITAL</u> | | | A. STATE <u>MARYLAND</u>
B. COUNTY <u>704</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<u>824 CHAPEL STREET</u> | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2-22-24</u> | 9. AGE (In years last birthday)
<u>45</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore Md</u> | |
| 13. FATHER'S NAME
<u>ROBERT SMITH</u> | | 14. MOTHER'S MAIDEN NAME
<u>ANNIE BASKETVILLE</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-20-9801</u> | | 17. INFORMANT
<u>Booker Sprigge</u> | |
| 18. <u>23-0-7</u> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Septicemia</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>Pararectal Abscess</u> | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>Diabetes Mellitus</u> | | | |
| | | (C) <u>Obesity</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Obesity</u> | | | | | |
| 19A. DATE OF OPERATION
<u>23 Feb 70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Abscess</u> | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1 Feb</u> 19 <u>70</u> to <u>5 Feb</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5 Feb</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>N. Rosenshein M.D.</u> | | 23B. DATE SIGNED
<u>5 Nov 1970</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>N. ROSENSHEIN M.D.</u> | |
| 23D. ADDRESS
<u>THE JOHNS HOPKINS HOSPITAL</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Buried</u> | 24B. DATE
<u>2-10-70</u> | 24C. NAME of CEMETERY or CREMATORY
<u>Northwood Cmt</u> | 24D. LOCATION (City, town, or county)
<u>Balt Md</u> | (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 11 1970</u> | 25B. NAME OF REGISTRAR
<u>Robert E. Baker</u> | 25C. FUNERAL DIRECTOR
<u>Booker Sprigge</u> | ADDRESS
<u>Baltimore, Md</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|------------------------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 70 1672 | | REG. NO. 70 1672 | |
| BIRTH NO. W-650 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Robert Wren</u> | | 2. DATE AND HOUR OF DEATH
<u>2/10/70</u> <u>6:40</u> A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>34 Bon Secours Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u>
B. COUNTY <u>2006</u>
C. CITY OR TOWN <u>Balto.</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>3125 Phelps La.</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9/19/95</u> | 9. AGE (in years last birthday)
<u>74</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Robert Wren</u> | | 14. MOTHER'S MAIDEN NAME
<u>Hilda Katie Williams</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>217-01-3268</u> | | 17. INFORMANT
<u>Chart</u> ADDRESS | |
| 18. <u>1-3-4-1-1</u> CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 days</u>
<u>5 days</u>
<u>18 days</u> | |
| 18. <u>1-3-4-1-1</u> CAUSE OF DEATH | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Cardiac Failure</u> | | <u>5 days</u> | |
| 18. <u>1-3-4-1-1</u> CAUSE OF DEATH | | (B) <u>Multiple Pulmonary Emboli</u>
DUE TO, OR AS A CONSEQUENCE OF: | | <u>5 days</u> | |
| 18. <u>1-3-4-1-1</u> CAUSE OF DEATH | | (C) <u>Operation - Abdominal Peritonitis</u>
DUE TO, OR AS A CONSEQUENCE OF: <u>resection of Rectal Carcinoma</u> | | <u>18 days</u> | |
| 18. <u>1-3-4-1-1</u> CAUSE OF DEATH | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>Rectal</u> | | | |
| 19A. DATE OF OPERATION
<u>1-23-70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Rectal Carcinoma</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>or Jan 5</u> 19 <u>70</u> to <u>Feb 10</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>Feb 9</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>W. L. Canfield M.B.C.H.B.</u> | | 23B. DATE SIGNED
<u>2. 10. 70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>W. L. Canfield M.B.C.H.B.</u> | |
| 23D. ADDRESS
<u>Bon Secours Hospital, Balto. 21223.</u> | | 23E. FUNERAL DIRECTOR
<u>E. Gray 800 - Wilson</u> | | 23F. ADDRESS
<u>21223</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Buried</u> | | 24B. DATE
<u>2-14-70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>White</u> | |
| 24D. LOCATION
<u>MD</u> | | 24E. DATE REC'D BY HEALTH DEPT.
<u>FEB 11 1970</u> | | 24F. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | |

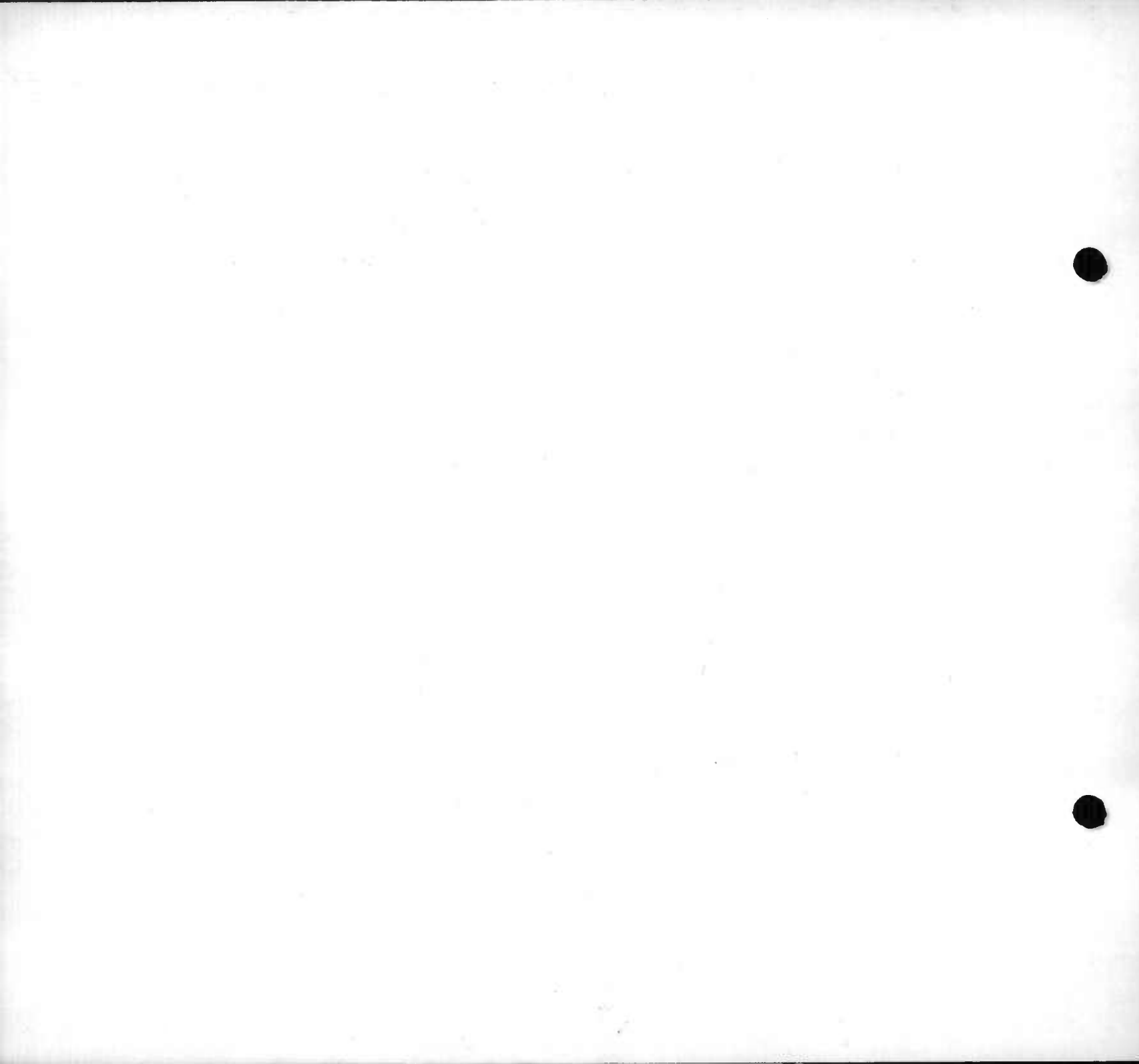
1944-45

2-22-45

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

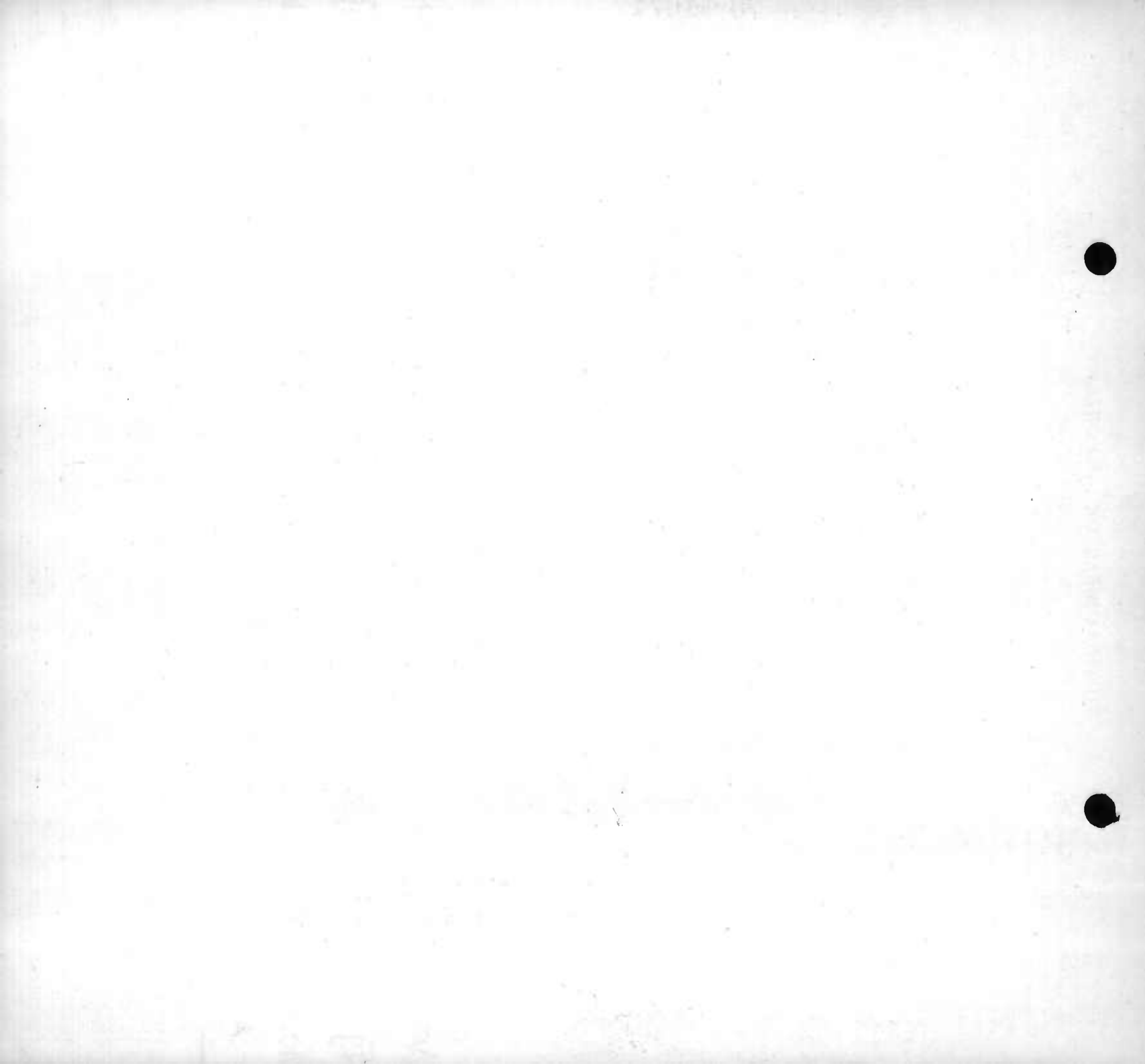
| H-125 70 1673 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1673 | |
|---|---------|--|--------------------------|---|--------------------------------|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | HOPKINS REBECCA W | | 2-6-70-928 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | |
| UNION MEMORIAL HOSPITAL | | | | Md Baltimore | |
| | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | | | BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | |
| | | | | 524 E 23RD ST. | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Female | Negro | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | UNKNOWN | 82 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | UNKNOWN | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| UNKNOWN | | | UNKNOWN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 167-30-294 | | Maggie Sheppard | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPTIC (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (APPROX.) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 01-07-70 to 02-06-70 that (I) (we) last saw the deceased alive on 02-06-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| J. P. Mikus | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| J. P. MIKUS | | | | UMH | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 2-11-70 | | Mt Auburn Cmt | |
| | | | | Balto | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 11 1970 | | Robert E. Taylor | | Edw. O. Wilson | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1674 | |
|--|--|---|--|--|--|
| J-520 70 1674 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <i>Blanchence Jones T</i> | | | | 2. DATE AND HOUR OF DEATH
<i>2-8-1970</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>2002</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Bon Secour Hosp. W.O.A.</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>Female</i> | | 6. RACE <i>Colored</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <i>4-25-1908</i> | | 9. AGE (In years last birthday) <i>61</i> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>None</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>John Jones</i> | | 14. MOTHER'S MAIDEN NAME <i>Blanche Loney</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Chene Staler</i> ADDRESS <i>Same</i> | |
| 18. <i>412.21</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
<i>Hypertensive Cardio-vascular Disease.</i>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>7 years</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/61</i> <i>1963</i> to <i>2/8/70</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/8/70</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>R. W. Reckling</i> | | | | 23B. DATE SIGNED <i>2/10/70</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Ralph W. Reckling MD</i> | | | | 23D. ADDRESS <i>2930 Baker Street Baltimore, Maryland 21216</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>2-12-70</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Not Urban Cent</i> | |
| 24D. LOCATION (City, town, or county) <i>Balto</i> | | 24E. STATE (State) <i>Md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 11 1970</i> | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Chapman Wilson</i> | | 25D. ADDRESS <i>Blanchence</i> | |



J-520

70 1675

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1675

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD C. JOYNES (JOYENS)

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

2

10

70

10:00 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

February 10, 1970

10:00 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

402

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

8-17-1892

10. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

706 W. Saratoga St.

11. BIRTHPLACE (State or foreign country)

Accomack Co., Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Clarence Joyens

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary Joyens

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

6-21-18 6-21-1919

17. SOCIAL
SECURITY NO.

220-12-6218

18. INFORMANT

ADDRESS

Mrs. Audrey Briscoe 662 Brisbane Road

19.

412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2/10/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-13-70

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Maryland

25A. DATE REC'D BY HEALTH-DEPT.

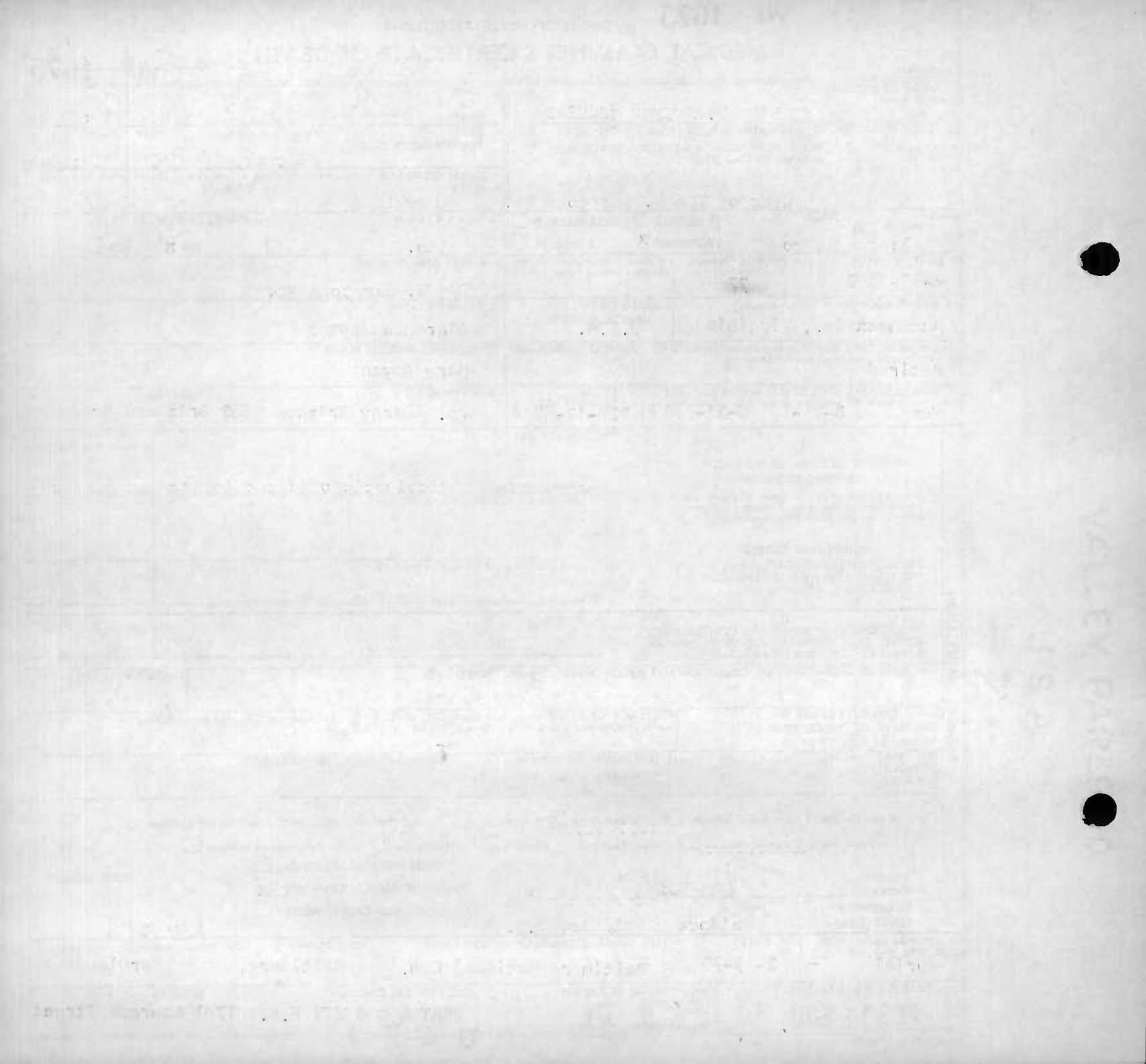
FEB 11 1970

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens Street

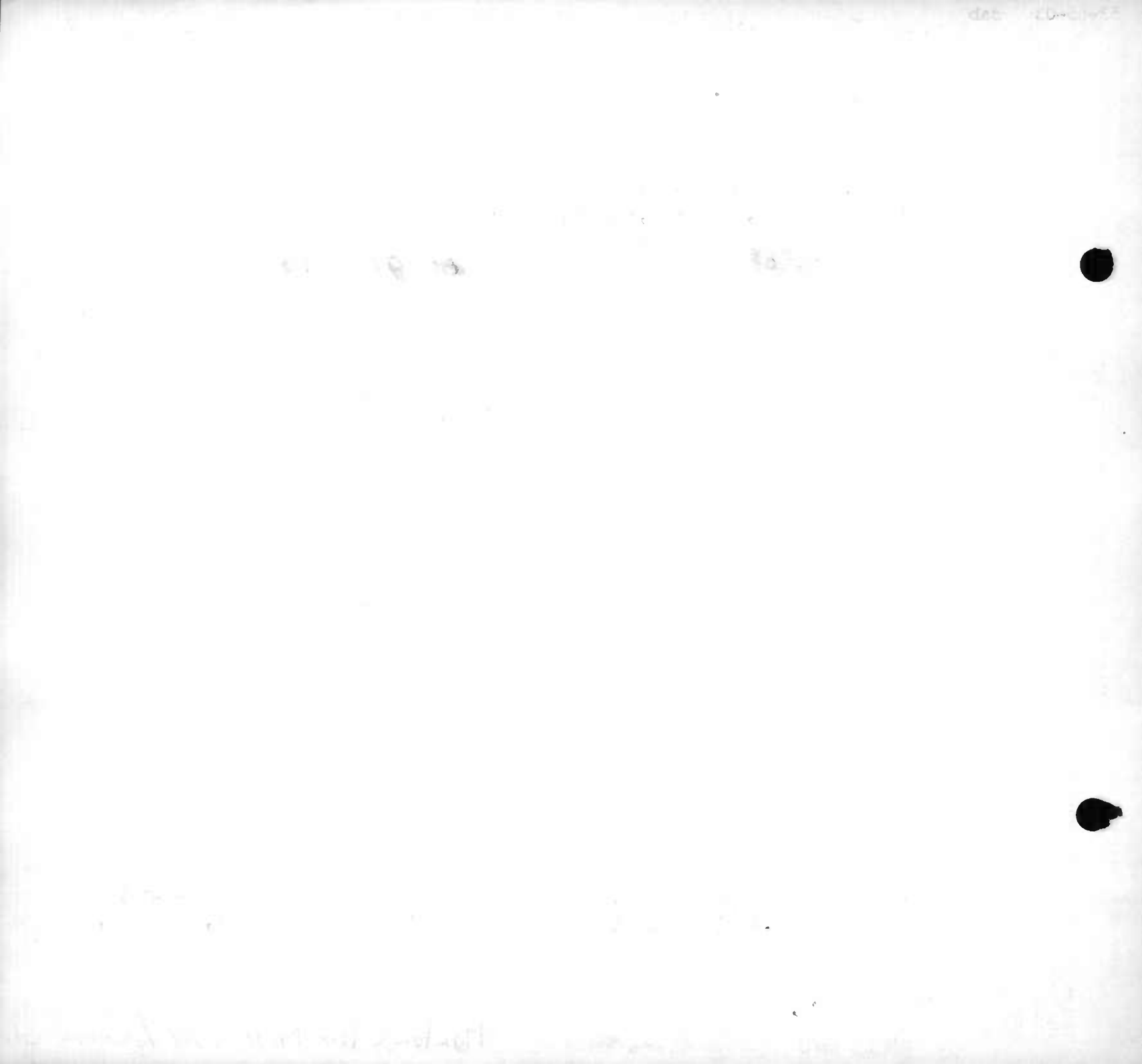


| 1 | | 70 1676 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1676 | |
|---|-------------------------|---|--|---|--|---|--|
| G-612 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. | |
| BIRTH NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) NELSON GRAVES | | | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> 2 9 70 1:45 p. M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
35 Church Home & Hospital | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
February 9, 1970 1:45 p. M. | | | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 301 | | | | | | | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH
9-24-1929 | | 10. AGE (In years last birthday) 40 | | E. STREET AND NUMBER
4 S. Caroline St. | | | |
| 11. BIRTHPLACE (State or foreign country)
Woodward, S. Carolina | | 12. CITIZEN OF
U.S.A. | | 13. FATHER'S NAME
James Graves | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME
Essie Graves | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Mrs. Corean Graves | | ADDRESS
278 Herring Court | |
| 19. 5718 I CAUSE OF DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE Fatty metamorphosis of the liver
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) _____
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (C) _____ | | | |
| 20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED
2/10/70 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-12-70 | | 24C. NAME OF CEMETERY or CREMATORY
Mount Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 11 1970 | | 25B. NAME OF REGISTRAR
Isidore Mihalakis, M.D. | | 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | | ADDRESS
1701 Laurens Street | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-150 | | 70 1677 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1677 | |
|---|-------------------------|--|-----------------------------------|---|---|---|---|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) GEORGE W. SPAIN | | | | 2. DATE AND HOUR OF DEATH
2-9-70 11:55 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
BALTIMORE CITY HOSPITALS
4940 Eastern Avenue, Baltimore, Maryland 21224 | | | | A. STATE
Md. | | B. COUNTY
1303 | |
| | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
2431, FRANCIS ST. 21216 | | | |
| 5. SEX
Male | 6. RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/6/96 | 9. AGE (in years last birthday)
73 | 10. Under 1 Yr. Months: Days: | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
N. CAROLINA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
GEORGE SPAIN | | | | 14. MOTHER'S MAIDEN NAME
ANNIE E. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217 09 8951 | | 17. INFORMANT
BCH-Records: 4940 Eastern Avenue | | ADDRESS
SAME | |
| 18. CAUSE OF DEATH
162.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
CARCINOMATOSIS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MOS. | |
| | | | | (B) CA OF THE LUNG
DUE TO, OR AS A CONSEQUENCE OF: | | 2 YRS.
MOS. | |
| | | | | (C) _____ | | | |
| 19A. DATE OF OPERATION
0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-6 19 70 to 2-9 19 70 that (I) (we) last saw the deceased alive on 2-9 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Rene P. de los Santos | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
2-9-1970 | |
| 23C. PHYSICIAN'S NAME (Type) Rene P. de los Santos | | | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
2/13/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | |
| 24D. LOCATION
Baltimore, Maryland | | | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 11 1970 | | | | 25B. NAME OF REGISTRAR
Rene P. de los Santos | | 25C. FUNERAL DIRECTOR
Mortuaria Byett-F.H. | |
| | | | | ADDRESS
1701 Laurens St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|---|--|
| A-620 70 1678 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1678 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>AYERS, Sadie</u> | | 2. DATE AND HOUR OF DEATH
<u>2-10-70</u> <u>7:45 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>1604</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Duikland Nursing Home</u>
<u>90 1501 Duikland St.</u>
<u>Baltimore, Md. #31216</u> | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>F</u> | | 6. RACE <u>N N</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
<u>3-17-89</u> | | 9. AGE (in years last birthday) <u>80</u> | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Litchfield, Kansas</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>George McDuffy</u> | | 14. MOTHER'S MAIDEN NAME
<u>Minnie Davis</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>284-14-6998</u> | | 17. INFORMANT
<u>Duikland Nursing Home - M. Duikland</u> | |
| 18. <u>412.41</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<u>VIRUS INFECTION & BRONCHITIS</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE UNK</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 DAYS</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indefinitely medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/28</u> 19 <u>67</u> to <u>2/10</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/7</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>N. Alan Harris, M.D.</u> | | 23B. DATE SIGNED
<u>2/10/70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>N. Alan Harris, M.D.</u> | |
| 23D. ADDRESS
<u>4200 EDMONDSON AVE.</u> | | 23E. CITY OR TOWN
<u>Baltimore</u> | | 23F. STATE
<u>Maryland</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/13/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Arbutus Mem. Park</u> | |
| 24D. LOCATION (City, town, or county)
<u>Baltimore</u> | | 24E. STATE
<u>Maryland</u> | | 24F. ZIP CODE
<u>21229</u> | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
<u>FEB 11 1970</u> | | 25B. NAME OF REGISTRAR
<u>JAMES E. HARRIS</u> | | 25C. FUNERAL DIRECTOR
<u>Walter J. Rupp</u> | |
| 25D. ADDRESS
<u>1701 Lawrence St.</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1679 | |
|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) TYLER, GEORGE H | | 2. DATE AND HOUR OF DEATH
2-7-70 7:35 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
KEY CIRCLE Hospice | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md.
B. COUNTY 2710 | | | |
| 5. SEX MALE | | 6. RACE N | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 8-16-99 | |
| 13. FATHER'S NAME
Robert Tyler | | 14. MOTHER'S MAIDEN NAME
Eliza Miles | | 9. AGE (in years last birthday) 70 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
212-32-3213 | | 17. INFORMANT
Mrs. Eliza Wilson | |
| 18. 440.91 | | CAUSE OF DEATH | | ADDRESS
7401 Linden Ave | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.

ANTECEDENT CAUSES

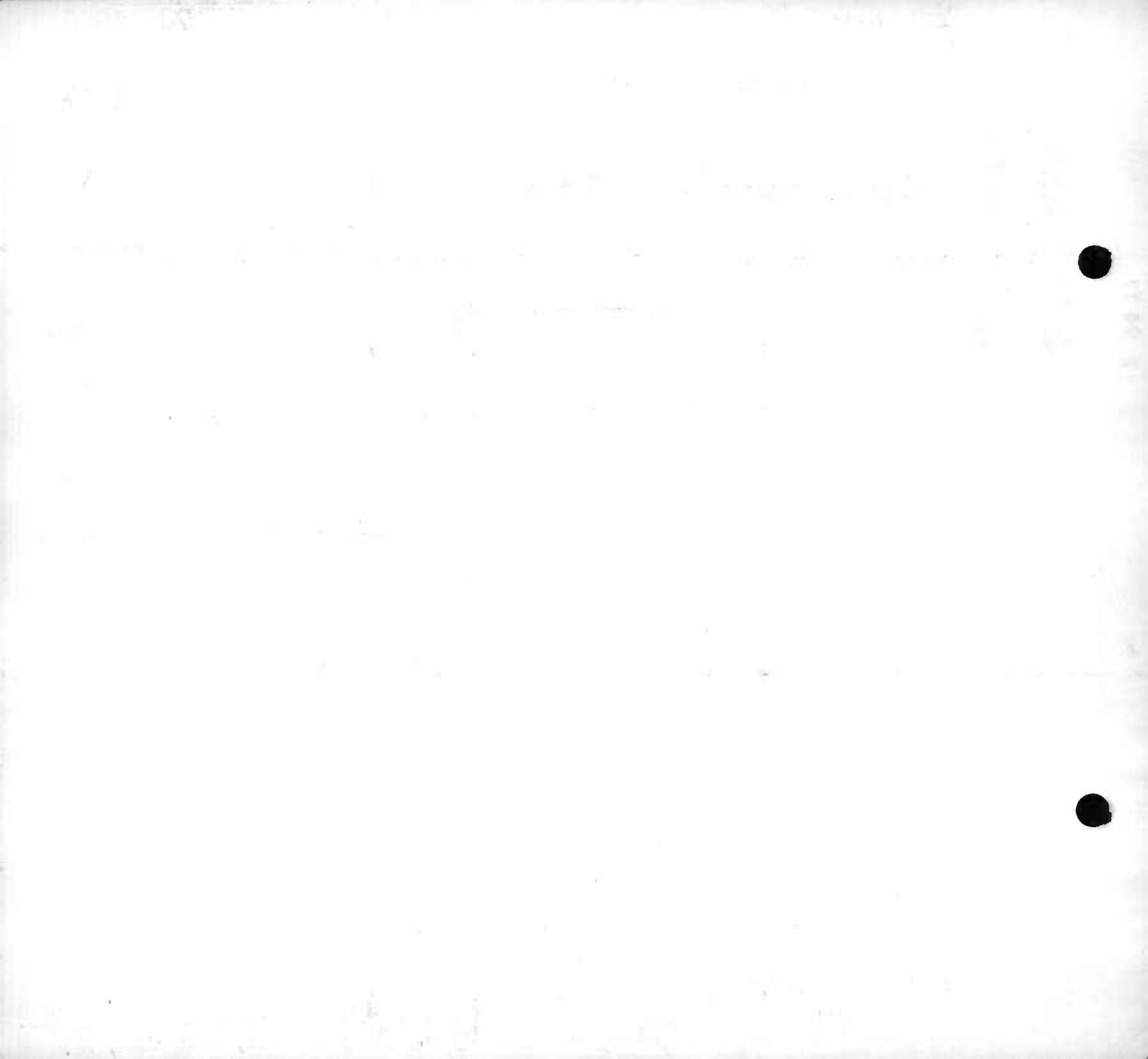
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Pulmonary embolism | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 yd | |
| (B) DUE TO, OR AS A CONSEQUENCE OF:
Hypertension | | | | 2 yd | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-08 19 69 to 2-7 19 70
that (I) (we) last saw the deceased alive on 2-6 19 70 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Richard R. Rigler | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type)
RICHARD R. RIGLER | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 2/11/70 | | Pleasant Rest Cem. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 11 1970 | | 25B. NAME OF REGISTRAR
John E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Morton & Dyett F.H. | |
| 24D. LOCATION (City, town, or county) (State)
Towson, Maryland | | 25D. ADDRESS
1 W. Overlea Ave Balts # 6 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 70 1680 | |
|--|-------------------------|---|--|---|---|
| BIRTH NO. E-245 70 1680 | | 1. NAME OF DECEASED
(Type or Print) VERA C. EKLUND | | 2. DATE AND HOUR OF DEATH
FEBRUARY 5, 1970, 8³⁰ A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

33 JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Cecil 5700 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
JOHNS HOPKINS HOSPITAL | | | C. CITY OR TOWN
Perryville | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | E. STREET AND NUMBER
Box 141 A. R.D. #1 | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/29/13 | 9. AGE (In years last birthday)
56 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Eden Creswell | | 14. MOTHER'S MAIDEN NAME
Eva Davis | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-44-0135 | | 17. INFORMANT
Carl E. Eklund, Perryville, Md. 21903 | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
MYOCARDIAL INFARCTION
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
RHEUMATIC AORTIC INSUFFICIENCY
RHEUMAT PNEUMONIA
RHEUMATIC HEART DISEASE | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 HOURS
10 YEARS
40 YEARS | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
PULMONARY EDEMA 2 DAYS
PNEUMOCOCCAL PNEUMONIA 4 DAYS | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 1/31 19 70 to 2/5 19 70 that (I) (we) last saw the deceased alive on 2/5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Robert S. Weinberg M.D. | | 23B. DATE SIGNED
2/5/70 | | 23C. PHYSICIAN'S NAME (Type)
ROBERT S. WEINBERG M.D. | |
| 23D. ADDRESS
JOHNS HOPKINS HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24B. DATE
Feb. 8, 1970 | | 24C. NAME OF CEMETERY OR CREMATORY
Principio Cemetery | | 24D. LOCATION (City, town, or county) (State)
Perryville Cecil Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 11 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Robert E. Taylor & Son, Perryville, Md. | |

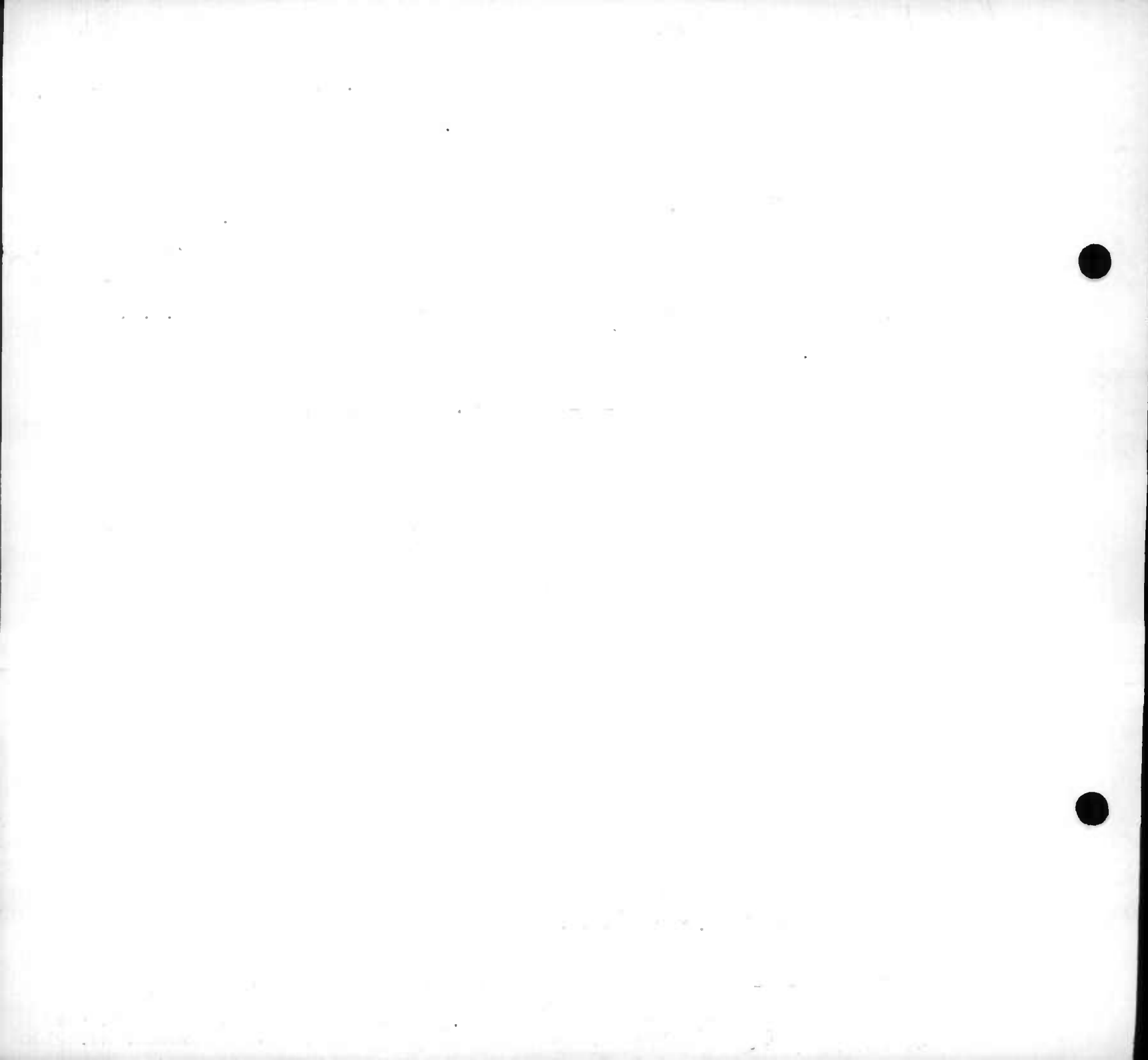


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|--|--|---|
| 8-550 70 1681 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1681 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Clarence Simon</u> | | | 2. DATE AND HOUR OF DEATH
<u>Feb. 6, 1970</u> <u>10:45 p.m.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>37 Mercy Hospital, Inc.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u>
B. COUNTY <u>2633</u>
C. CITY OR TOWN <u>Baltimore</u>
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>3101 Kentucky Ave.</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11/15/97</u> | 9. AGE (in years last birthday)
<u>72</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Dep. Sheriff</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Balto/ City</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Kentucky</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>John E. Simon</u> | | 14. MOTHER'S MAIDEN NAME
<u>Matilda Young</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>212-30-4723</u> | | 17. INFORMANT
<u>Mrs. Betty Simon, Same as # 4</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>1621 I</u>
CAUSE OF DEATH
<u>Congestive Heart Failure</u>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Cancer of the Lung</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<u>Bronchopneumonia</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>16 mo</u>
<u>4 days</u> | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> and that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Stephen L. Winter, M.D.</u> | | | 23B. DATE SIGNED
<u>2-6-70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Stephen L. Winter, M.D.</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 24B. DATE
<u>2-10-1970</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Prospect Hill Cemetery</u> |
| 24D. LOCATION
<u>Towson, Maryland 21204</u> | | | 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 11 1970</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, R.D.</u> | | | 25C. FUNERAL DIRECTOR
<u>Wm. O. Cook-Brooks</u> | | |
| 25D. ADDRESS
<u>Towson, Md. 21204</u> | | | 25E. ADDRESS
<u>Towson, Md. 21204</u> | | |



Released and approved by Medical Examiner 2-6-70 J. McGrath

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

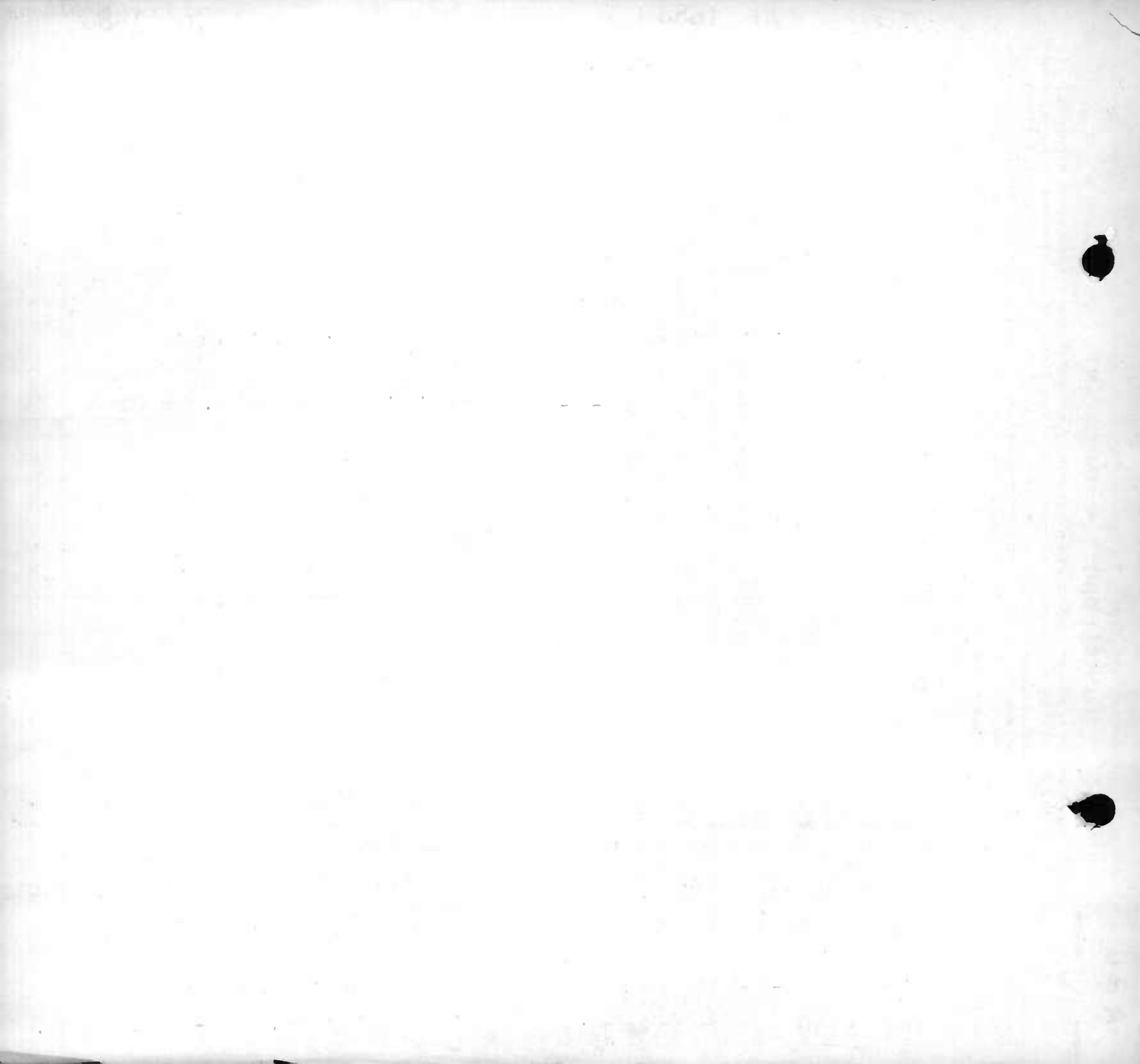
| | | | | | | | |
|--|--|--|--|--|--|--|--|
| G-615 | | 70 1682 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 70 1682 | |
| BIRTH NO. | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| GRIFFIN, BEULAH P. | | | | FEBRUARY 6th, 1970 | | 6:00 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| UNION MEMORIAL HOSPITAL | | | | MARYLAND 2714 | | | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED, NEVER MARRIED | |
| FEMALE | | WHITE | | WIDOWED, DIVORCED (specify) | | Widowed | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 03/02/86 | | 83 | | RETIRED | | Housewife | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| MARYLAND | | U. S. A. | | GEORGE PARKS | | IDA PARKS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 212-30-2975 | | HAZEL KELLY | | 145 MARBUTH AVENUE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | BRONCHOPNEUMONIA
ARTERIOESCLEROTIC CARDIOVASCULAR DISEASE
FRACTURED HIP | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| <input checked="" type="checkbox"/> | | HOME | | 4631 SCHENLEY ROAD | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| 24 70 11 30 AM | | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | PT. SLIPPED AND FELL DOWN TO FLOOR. | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 24th 19 70 to FEBRUARY 6th 19 70, that (I) (we) last saw the deceased alive on FEBRUARY 6th 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| J. Cabrera | | | | | | 2/6/70 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| J. CABRERA | | | | UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2/9/70 | | Prospect Hill | | Towson Balto. Co. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| FEB 11 1970 | | Robert E. Taylor, Jr. | | Wm. Cook-Brooks Towson Inc
1050 York Road Baltimore, Md. 21204 | | | |

5-2-50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1683 | |
|--|------------------|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> B-316 70 1683 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | WILLIAM H. BEDFORD
BEDFORD, WILLIAM M. | | 2. DATE AND HOUR OF DEATH
2/11/70 - 11 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY
MD. BALTO. 202 | | |
| NORTH CHARLES- | | | C. CITY OR TOWN
BALTO. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
301 S. ANN ST- | | |
| 5. SEX
M | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 13, 1897 | 9. AGE (In years last birthday)
72 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETIRED. | | Auto Mechanic | | MARYLAND | |
| 13. FATHER'S NAME
DON'T KNOW | | | 14. MOTHER'S MAIDEN NAME
Anna Marie Staline | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No | | | 213-03-6071 | | Mrs Lillie Bedford 301 S. Ann Street |
| 18. 482.31
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
PNEUMONIA - LOBAR | | |
| | | | (B) STAPHYLOCOCCUS AUREUS INFECTION
DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| D | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JAN - 24 1970 to Feb - 11 1970, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. M. Gorn | | | | 23B. DATE SIGNED
Feb 11 - 70 | |
| 23C. PHYSICIAN'S NAME (Type)
K. KRULEVITZ | | | | 23D. ADDRESS
115 W. MONUMENT ST. BALTO. MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2-14-1970 | | Loudon Park | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 18 1970 | | Robert E. Taylor | | Lilly & Zeiler Inc. 1901-07 Eastern Ave. | |

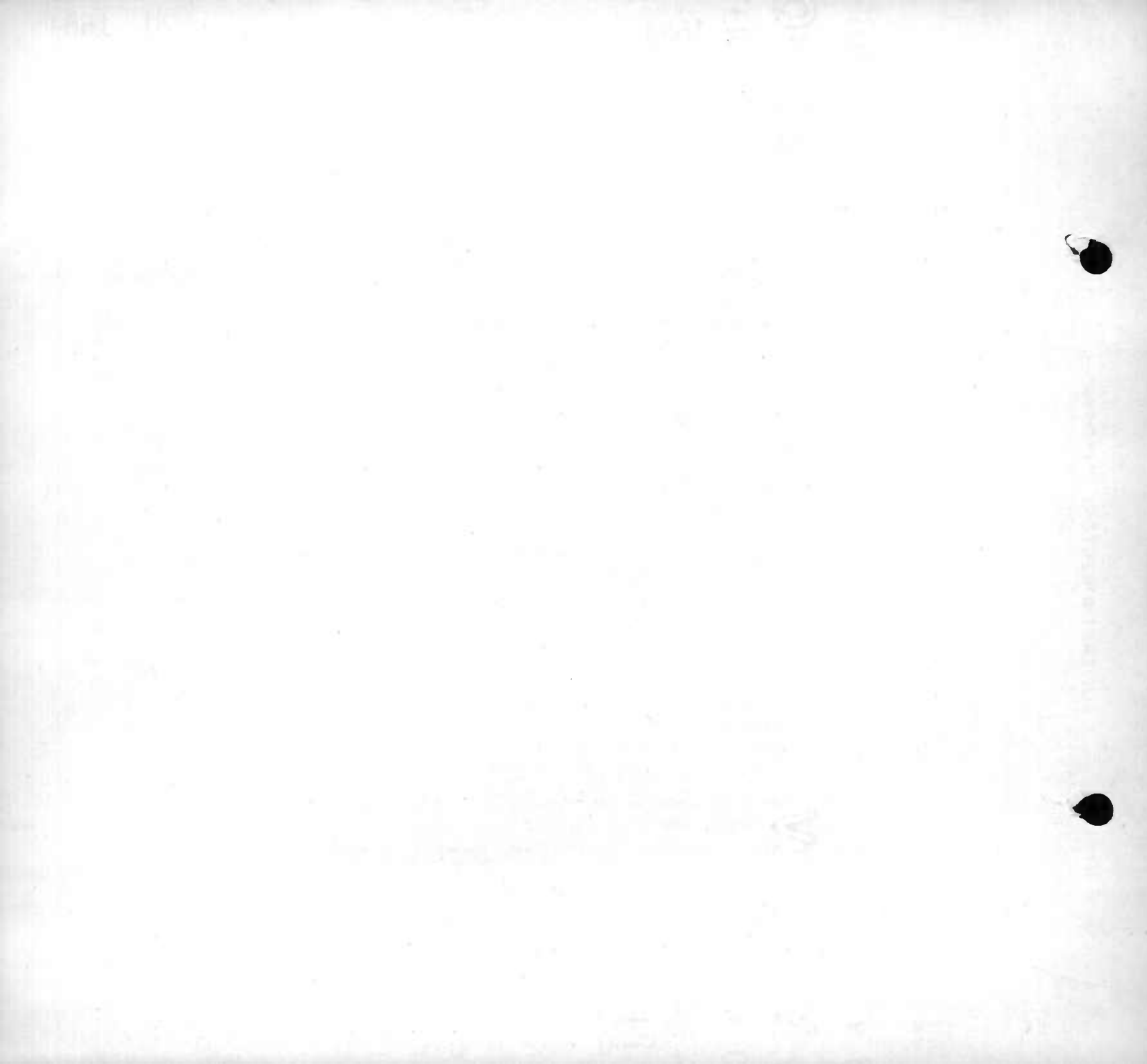


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| K-450 70 1684 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1684 | |
|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) KELLAM, RUFUS | | | | 2. DATE AND HOUR OF DEATH
2-11-70 13:45 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
46 LUTHERAN HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 1608 | | | |
| 5. SEX
Male | | 6. RACE
Negroid | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
5-14-89 | |
| 9. AGE (In years lost birthday)
80 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | 11. BIRTHPLACE (State or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Levie Kellam | | | | 14. MOTHER'S MAIDEN NAME
Rachel Knox | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
YES 8/22/18 to 12/13/18 | | 16. SOCIAL SECURITY NO.
214-44-5947 | | 17. INFORMANT
Louise Smith - niece - same | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
412.31 | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular disease with
(B) Coronary insufficiency.
(C) _____ | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-10-70 to 2-11-70 19 70 to 2-11-70 19 70 , that (I) (we) last saw the deceased alive on 2-11-70 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Violeta R Gamarra RMD | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type)
VIOLETA R GAMARRA R. M.D. | | | | 23D. ADDRESS
730 Ashburton St. Bal. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-16-70 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Pk. Nat'l. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Bailey | | 25C. FUNERAL DIRECTOR
V. R. Bailey | | ADDRESS
Kelson R. H. 1348 N. Calhoun St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

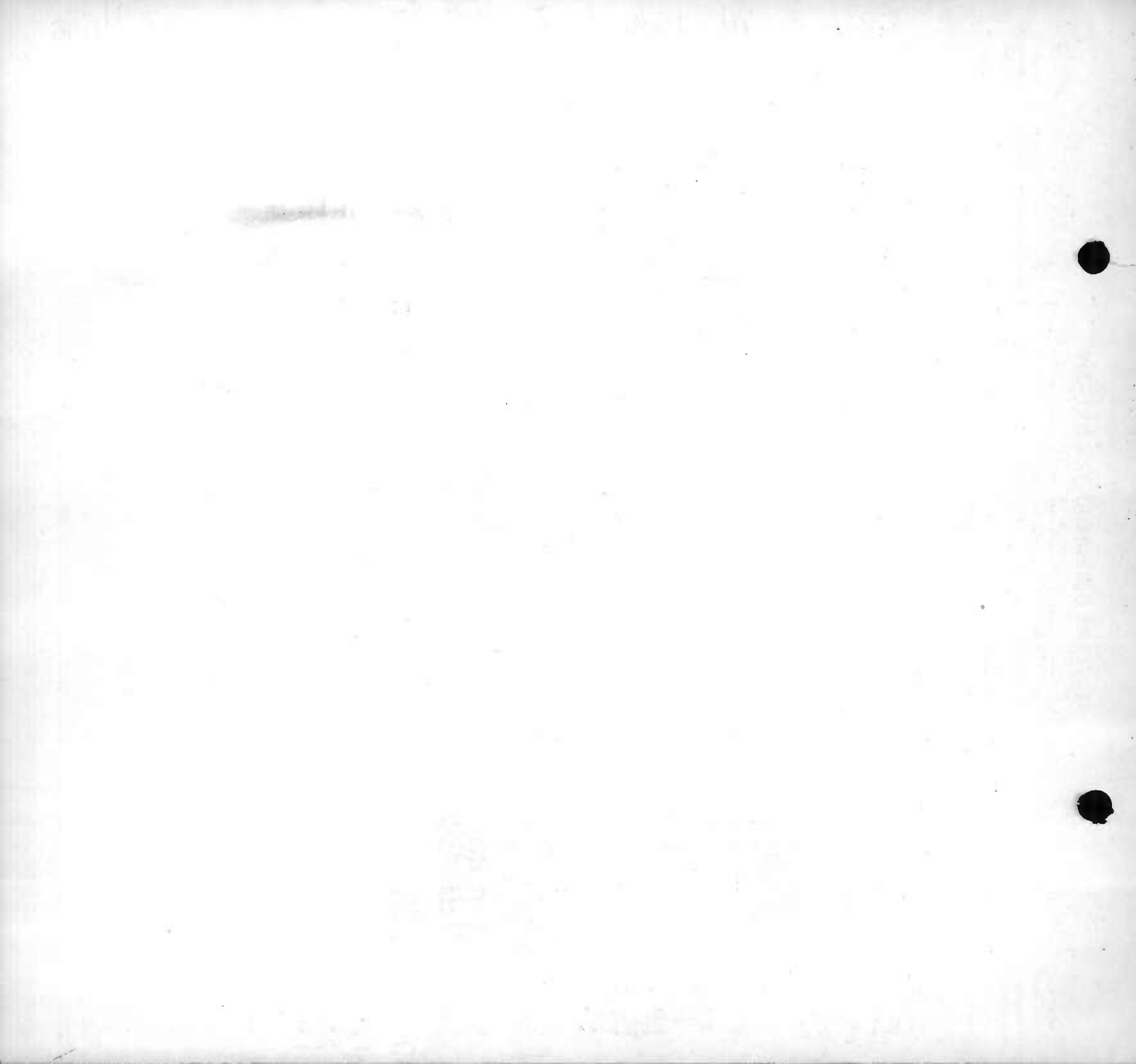
| | | | |
|--|---|--|---|
| <div style="display: flex; justify-content: space-between;"> D-250 70 1685 </div> <div style="display: flex; justify-content: space-between;"> BALTIMORE CITY HEALTH DEPARTMENT 70 1685 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | REG. NO. [REDACTED] | |
| BIRTH NO. [REDACTED]
1. NAME OF DECEASED
(Type or Print) <i>Dyson, Janie E.</i> | | 2. DATE AND HOUR OF DEATH
<i>2-10-70</i> <i>12:20 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>South Baltimore General Hospital</i>
<i>43</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>city</i>
C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>2123 David Hill Ave</i> | |
| 5. SEX <i>Y</i>
6. RACE <i>C</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>4/23/35</i>
9. AGE (in years lost birth days) <i>44</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME
<i>Samuel Boyd</i> | | 14. MOTHER'S MAIDEN NAME
<i>Hester McKinley</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT
<i>Thomas Dyson</i> ADDRESS <i>same</i> | |
| 18. <i>5-8-2-1</i> CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<i>Cardiac Arrest</i>
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2-8-70</i> 19 to <i>2-10-70</i> 19 that (I) (we) last saw the deceased alive on <i>2-10-70</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>Daniel M. Howell</i> MD | | 23B. DATE SIGNED
<i>2-10-70</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
<i>S. Balto. Gen. Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<i>2-14-70</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY
<i>Mt. Calvary Cem.</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Balto. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 13 1970</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Bailey, Jr.</i> | |
| 25C. FUNERAL DIRECTOR
<i>W. R. Bailey</i> | | ADDRESS
<i>1348 N. Calhoun St.</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|------------------|---|--------------------------------|---|---|--|--|
| M-624 | | 70 1686 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1686 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) MORSELL FREE LAND | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH
2-10-1970 7:00 P. M. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
LUTHERAN HOSPITAL
46730 ASHBURTON STREET
BALTIMORE MD. 21216 | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 15-01
C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1617 WESTWOOD AVENUE | | | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-20-1889 | 9. AGE (In years last birthday)
80 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | 11. BIRTHPLACE (State or foreign country)
Md. | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
217-01-1933A | | 17. INFORMANT ADDRESS
MOZEL Hollomon - 1805 Presstman | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF
Military Tuberculosis
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) General Debility & Malnutrition | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Prem Lal M.B.B.S. | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type)
PREM LAL M.B.B.S. | | | | 23D. ADDRESS
LUTHERAN HOSPITAL
730 ASHBURTON ST. BALTIMORE MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-14-70 | | 24C. NAME OF CEMETERY or CREMATORY
ARBUSUS Mem. Pk. | | 24D. LOCATION (City, town, or county) (State)
BALTO. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | | | 25B. NAME OF REGISTRAR
Robert E. Bailey | | 25C. FUNERAL DIRECTOR V. BAILEY
KELSON R.H. 1348 CALHOUN ST. | |



FUNERAL DIRECTOR: IMPORTANT

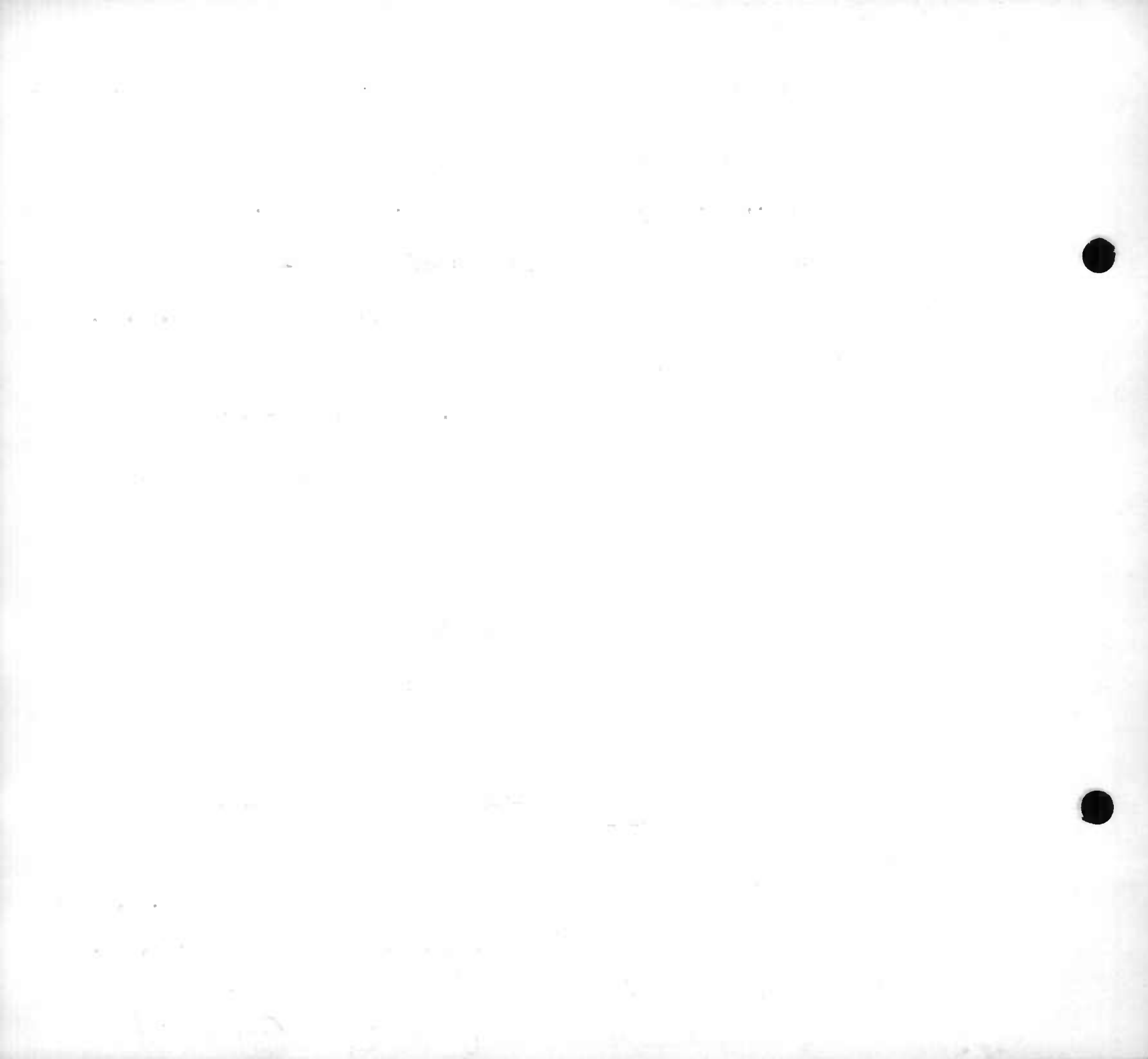
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|-------------------------------------|---|---|
| W-452 70 1687 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1687 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) ANDREW WILLIAMS | | 2. DATE AND HOUR OF DEATH
FEB. 8, 1970 9:05 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland 8. COUNTY 1504 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
2530 Pennsylvania Ave. Baltimore, Md. | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
2530 Pennsylvania Ave. | | | | | |
| 5. SEX
M | 6. RACE
B | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/23/06 | 9. AGE (In years last birthday)
63 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Longshoreman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
unknown | | 14. MOTHER'S MARDEN NAME
Frances Eldridge | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
133-12-6485 | | 17. INFORMANT Frances Eldridge Eleanor Campbell ADDRESS same | |
| 18. 162-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Bronchogenic Carcinoma of lung
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | |
| 19A. DATE OF OPERATION
0 N/A | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, lactory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1964 to 2/8 19 70 , that (I) (we) last saw the deceased alive on 2/8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
D. W. STEWART, M.D. | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
2/8/70 | |
| 23C. PHYSICIAN'S NAME (Type)
D. W. STEWART | | 23D. ADDRESS
2300 Garrison Blvd. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-13-70 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 12 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
V. B. Biley ADDRESS
Kelson T. H. 1348 Calhoun St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1688</u> | |
|--|-------------------------|---|-------------------------------------|--|---|
| <p><u>S-354</u> <u>70</u> <u>1688</u></p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED
(Type or Print) <u>Stanley, Walter</u></p> | | <p>2. DATE AND HOUR OF DEATH
<u>2-9-70</u> <u>7:35</u> A.M.</p> | | | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Provident Hospital</u>
<u>1514 Divison Street</u>
<u>Balto., Md. 21217</u></p> | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>1501</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>1533 N. Gilmore St.</u></p> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>11-22-26</u> | 9. AGE (In years last birthday)
<u>43</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unemployed</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore</u> | |
| 13. FATHER'S NAME
<u>Walter Stanley</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Buchanan</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mrs. Serita Bracco-Cousin</u> ADDRESS <u>Same</u> | |
| <p>18. <u>250.01-303.9</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetic Keto-acidosis</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <u>Alcoholism</u></p> | | | |
| <p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u></p> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>2-8-70</u> 19 to <u>2-9-70</u> 19 that (I) (we) last saw the deceased alive on <u>2-9-70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | |
| 23A. SIGNATURE
<u>G. Tengco MD</u> | | | | 23B. DATE SIGNED
<u>Feb. 9, 1970</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
<u>1514 Divison Street Baltimore, Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>2/13/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Balto. National Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>5501 Frederick Ave. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 13 1970</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Walter E. Elctor 1129 N. Calhoun St.</u> | | | |





BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
Willie Miller, Jr. | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
Month Day Year Hour
2 7 70 7:26 p M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
33 Johns Hopkins Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
2 7 70 7:26 p M. | |
| 6. SEX
male | | 7. RACE
colored | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 807 | |
| 9. DATE OF BIRTH
May 7 1935 | | 10. AGE (In years lost birthday) 34
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Wilson N.C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Willie Miller | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
mechanic | |
| 15. MOTHER'S MAIDEN NAME
Mary Spruill | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Mary Taylor 1915 E Federal St | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
E 812.0
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
street | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
20th and Aisquith Sts. 908 | | 22D. TIME OF INJURY (Approx.)
2 7 70 7:00 p.m. | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
driver in auto-auto collision | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz M.D.
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
Deputy Chief Medical Examiner 2/8/70
DATE SIGNED | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Feb 11/70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Arbutus MD | |
| 25A. NAME OF REGISTRAR
FEB 15 1970 | | 25B. FUNERAL DIRECTOR
Joseph E. Felickson 1129 N. Calver | |

0031 05

0001 05

EXAMINER'S CERTIFICATE OF RESULTS

ACADEMIC BOND

[Handwritten signature]

1
B-525 70 1691 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 1691

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
Dorothy Benjamin | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
2 6 70 10:05 p.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1114 Central Ave. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
2 6 70 10:05 p.m. | |
| 6. SEX
female | | 7. RACE
colored | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 1001 | |
| 9. DATE OF BIRTH
Oct 6, 1927 | | 10. AGE (In years last birthday) 42
If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
N.C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 13. FATHER'S NAME
Unknown | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 15. MOTHER'S MAIDEN NAME
Unknown | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Arthur Willis | |
| 19. 571.8 | | CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
Fatty alteration of liver
DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
Deputy Chief Medical Examiner
2/7/70 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Feb 13/70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Westport | | 24D. LOCATION (City, town, or county) (State)
Westport | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Arthur Willis | |
| 25C. FUNERAL DIRECTOR
Arthur Willis | | ADDRESS
1129 N. Calver St. | |

BIRTH NO.

REG. NO.

VS 151-REV. 1/1/68

1001 101

1001 101 1001 101 1001 101

ACADIPMIX 1001 101

1001 101

1001 101

1001 101

1001 101

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1693

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CLARANCE MARSHALL

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

6. SEX

Male

7. RACE

NEGRO

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

11/7/17

10. AGE (In years
last birthday)

52

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1516 E. Preston St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Clarence Marshall Sr.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Electrician

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Laura Gibson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or date of service)

Yes W W II

17. SOCIAL
SECURITY NO.

18. INFORMANT

Doris Capps-1516 E. Preston St.

ADDRESS

CAUSE OF DEATH

Emphysema with chronic pulmonary hypertrophy

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO OR AS A CONSEQUENCE OF:

and chronic cor pulmonale

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-9-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2/13/70

24C. NAME OF CEMETERY or CREMATORY

Balto. National Cem.

24D. LOCATION (City, town, or county)

5501 Grubbs Ave. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 13 1970

25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

Walter C. Elbert 11297 Cawth St.

ADDRESS

NO. 103

RECEIVED

NO. 103

10

10

10

10

10

10

10

10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

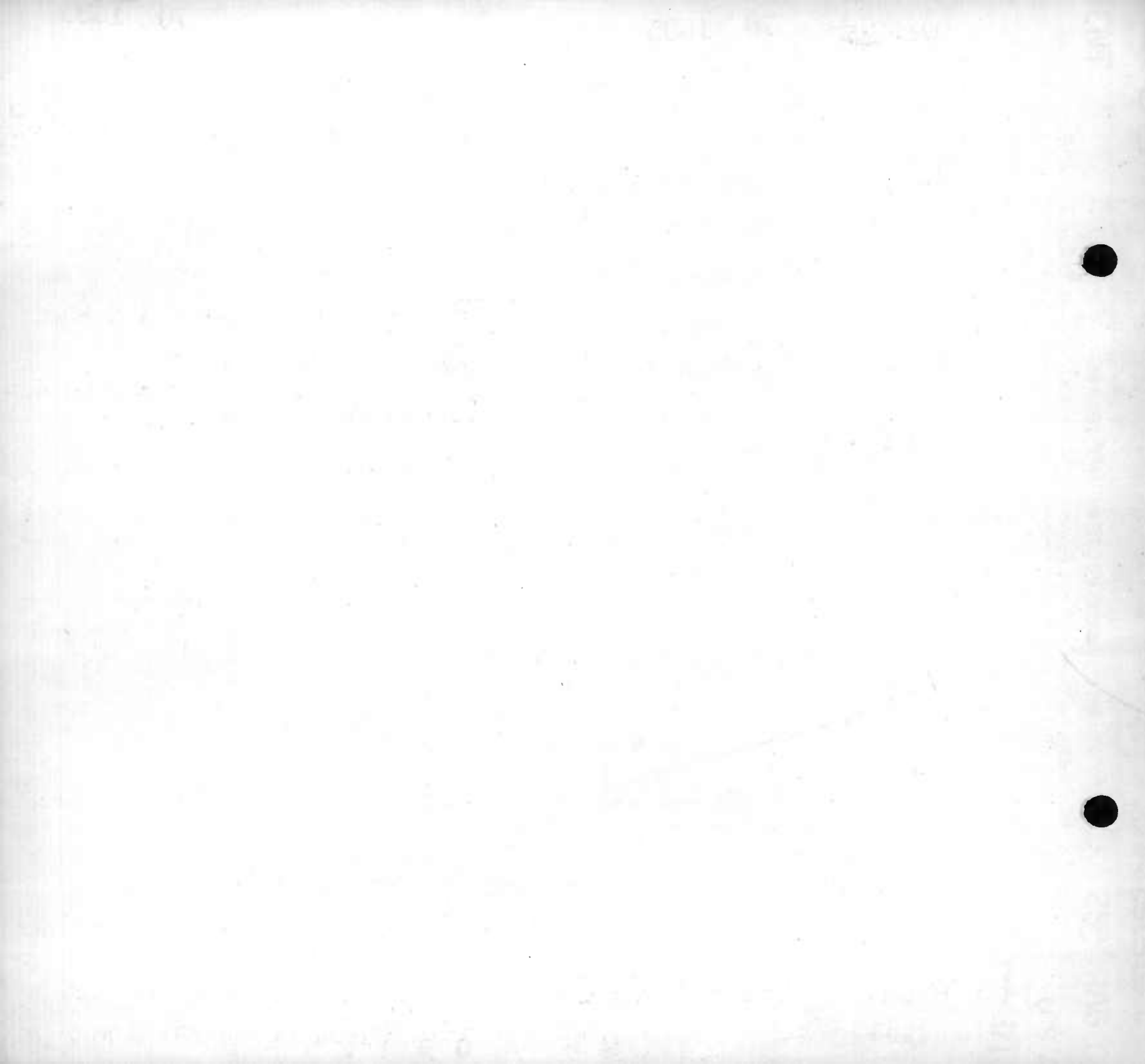
| | | | | | |
|--|--|--|--|---|--|
| S-610 70 1694 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | 70 1694 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) MABEL SHARP | | 2. DATE AND HOUR OF DEATH
2/9/70 7:45 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE CITY | | 605 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
JOHNS HOPKINS HOSPITAL
33 | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
213 N. SPRING COURT | | 5. SEX
F | | 6. RACE
N | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/18/98 | | 9. AGE (in years last birthday)
71 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEKEEPER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Otis Johnson | | 14. MOTHER'S MAIDEN NAME
Emma? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
PATIENT'S COART (JH # 15 5185) | |
| 18. 397.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
CHF | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 YEARS | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Rheumatic valvular disease | | (B) DUE TO, OR AS A CONSEQUENCE OF:
40 YEARS | |
| (C) | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
VENTRICULAR FIBRILLATION | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____
that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Thomas S. Inui
DEGREE | |
| 23B. DATE SIGNED
2/9/70 | | 23C. PHYSICIAN'S NAME (Type)
Thomas S. Inui | | 23D. ADDRESS
The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/14/70 | | 24C. NAME of CEMETERY or CREMATORY
Carmen M. Park | |
| 24D. LOCATION (City, town, or county) (State)
Laurel Md. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
John C. Clifton | | 25D. ADDRESS
1129 N. Carroll St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|--|--|--|---|--|
| W-252 70 1695 | | 70 1695 | | 70 1695 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Darlene Washington</i> | | 2. DATE AND HOUR OF DEATH
<i>1-27-70 9 A M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Lutheran Hospital of Md.</i> | | A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>46</i> | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <i>1608</i> | |
| 5. SEX
<i>F</i> | | 6. RACE
<i>Negro</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>None</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>-</i> | | 8. DATE OF BIRTH
<i>1-11-61</i> | |
| 13. FATHER'S NAME
<i>Oliver W. Washington</i> | | 14. MOTHER'S MAIDEN NAME
<i>Blanche V. Laws</i> | | 9. AGE (In years last birthday) <i>9</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | 16. SOCIAL SECURITY NO.
<i>-</i> | | 17. INFORMANT
<i>Yvonne L. Johnson</i> | |
| 18. <i>569.9</i> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<i>Cardiovascular Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <i>Anemia</i>
DUE TO, OR AS A CONSEQUENCE OF:
(C) <i>upper G.I. bleeding</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>6 days</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>1-22-70</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>upper G.I. bleeding</i> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)
<i>No injury</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<i>No injury</i> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<i>-</i> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<i>No injury</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-27</i> 1970 to <i>1-27</i> 1970, that (I) (we) lost saw the deceased alive on <i>11 PM Jan 26</i> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>M. Jalali</i> | | | | 23B. DATE SIGNED
<i>1-27-70</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>MEHRDAD JALALI</i> | | | | 23D. ADDRESS
<i>Lutheran Hosp 11 Md. Baltimore Md 21216</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>1-31-70</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Calvary Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>ANN ARUNDEL Co.</i> | | 24E. FUNERAL DIRECTOR
<i>J. B. Brown & Son</i> | | 24F. ADDRESS
<i>123 W. Montgomery St.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 13 1970</i> | | 25B. NAME OF REGISTRAR
<i>70000</i> | | 25C. FUNERAL DIRECTOR
<i>J. B. Brown & Son</i> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1696

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KAREN NEAL

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

1

30

70

11:03 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

D.O.A.

South Baltimore General Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

January 30, 1970

11:03 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

2543

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

Female

Negro

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

II * * *

10. AGE (In years
last birthday)If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

2

E. STREET AND NUMBER

2543 Norfolk XXX. Street 2354

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Ben Huff

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary NEAL XXX 2354 Norfolk street

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mary Neal 2354 Norfolk street

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Sudden death in infancy
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)22E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/30/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-3-70

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE CITY

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FEB 13 1970

Robert E. ...

Isaiah L. Brown & Son

108 W. Montgomery Street

NO. 1000

RECEIVED BY 2 CENTRAL BANK

ASAPLY FOUND

10-10-10

10-10-10

10-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1697 |
|---|--|---|---|---|
| BIRTH NO.
D-252 70 1697 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) MR WILLIE DICKENS. | | 2. DATE AND HOUR OF DEATH
2/5/70 12:55 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
BON SECOURS HOSPITAL 34 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1300 W. Lombard St. | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/26/71 | 9. AGE (in years last birthday) 99 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
Unknown | | |
| 11. BIRTHPLACE (State or foreign country)
Unknown | | 12. CITIZEN OF WHAT COUNTRY?
Unknown | | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
218-07-2133 | | 17. INFORMANT
Frances |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
Acute pulmonary edema not known
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
1(Month) 1(Day) 1(Year) 1(Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 2-1 19 70 to 2/5 19 70 that (I) (we) last saw the deceased alive on 2-5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
J. Vongvattunyu | | 23B. DATE SIGNED
2/5/70 | | 23C. PHYSICIAN'S NAME (Type)
V. VONGVATUNYU |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-9-70 | | 24C. NAME of CEMETERY or CREMATORY
Mountt Auburn |
| 24D. LOCATION (City, town, or county) (State)
Baltimore City | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | |
| 25B. FUNERAL DIRECTOR
Brown Sons M.S. | | 25C. ADDRESS
1300 W. Lombard St. | | |

burial

2-9-70 Mount Auburn

Baltimore City

00 9-2-70

10

2/2

10

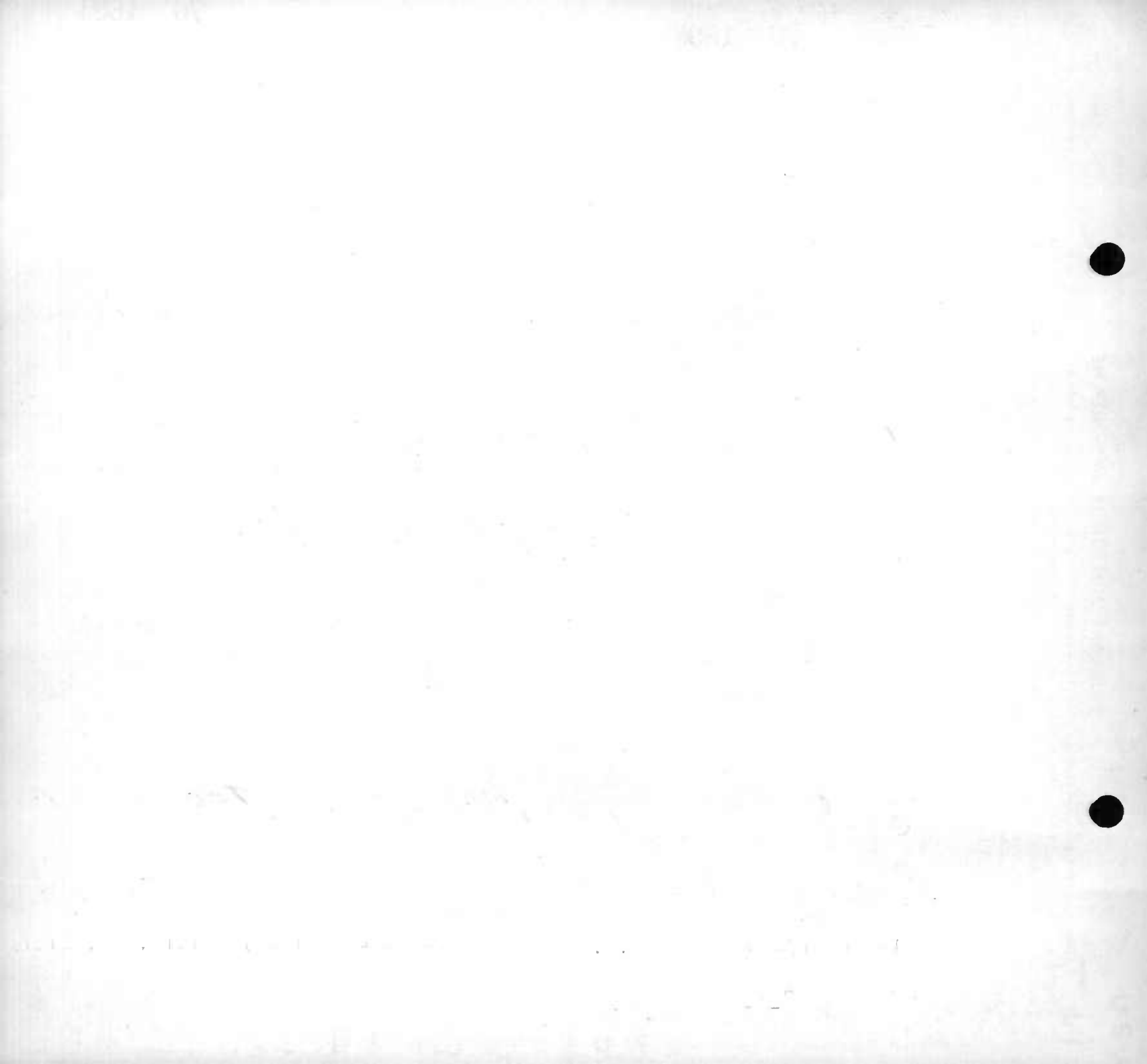
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
70 1698
REG. NO. 70 1698

L-142 70 1698
CERTIFICATE OF DEATH

| | | | | | |
|--|-------------------------|---|---------------------------------------|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Love, Ozzie</i> | | 2. DATE AND HOUR OF DEATH
<i>2/3/70 7:30 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>md.</i> B. COUNTY <i>1601</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>George Washing Nursing Home</i>
<i>90</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<i>Balto</i> | |
| | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
<i>914 Edmondson AVE</i> | |
| 5. SEX
<i>MALE</i> | 6. RACE
<i>Negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>10/25/1893</i> | 9. AGE (in years last birthday)
<i>77</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Construction worker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Georgia</i> | |
| 13. FATHER'S NAME
<i>Love, Willie</i> | | 14. MOTHER'S MAIDEN NAME
<i>Hannah</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>Unknown</i> | | 16. SOCIAL SECURITY NO.
<i>228-07-1067-A</i> | | 17. INFORMANT
<i>Chart</i> | |
| | | ADDRESS
<i>607 Penn Ave</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>412.3 I Arteriosclerotic Heart Disease</i> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Congestive Heart Failure</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Years</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Pneumonia</i> | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<i>Pneumonia</i> | | (C) <i>2 wks.</i> | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>MAY 29 1969</i> to <i>FEB 3 1970</i> , that (1) (we) last saw the deceased alive on <i>1-31-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Richard Tyson, M.D.</i> | | | | 23B. DATE SIGNED
<i>4 Feb 70</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Richard Tyson</i> | | | | 23D. ADDRESS
<i>2320 Eutaw Place, Baltio, Md. 21217</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<i>2-7-70</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>MT Auburn</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore City</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 13 1970</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. ...</i> | |
| 25C. FUNERAL DIRECTOR
<i>Prayer Sons</i> | | ADDRESS
<i>123 W. Montgomery St</i> | | | |

VS 150-REV. 1/1-78



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| T-514 70 1699 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1699 | |
|---|------------|--|--------------------------|--|----------------------------|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | FURMAN L. TEMPLETON | | FEBRUARY 10, 1970 7: P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE MARYLAND | |
| 00 1502 McCULLOH STREET | | | | C. CITY OR TOWN BALTIMORE | |
| | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 1502 McCULLOH STREET | |
| 5. SEX MALE | 6. RACE C. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-15-08 | 9. AGE (In years last birthday) 61 | II Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Secretary | | Balto. Urban League | | Hackensack, New Jersey | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Frederick B. Templeton | | Henrietta Billings | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 220-22-3765 | | Irene R. Templeton - 1502 McCulloh St. | |
| 18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 1962 | |
| ANTECEDENT CAUSES | | B. DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | C. DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CORONARY INSUFFICIENCY | | 1962 | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | N | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1939 19 to Feb 10 th 1970 that (I) (we) lost saw the deceased alive on Feb 7 th 1970 and that (in my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| RAYNER BROWNE, M.D. 1500 EAST MADISON ST. BALTIMORE, MD., 21206 | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| | | | | 23E. DATE SIGNED 2-12-70 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2-14-70 | | Arbutus Memorial Park | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 13 1970 | | Robert E. Taylor, M.D. | | Charles R. Law | |
| | | | | ADDRESS 802 Madison Ave. | |

U.S. AIR FORCE
OFFICE OF THE
SECRETARY
WASHINGTON, D.C. 20330

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|-----------------------------------|--|---|
| S-530
BIRTH NO. 70 1700 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 70 1700 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) AMBROSE SMITH | | 2. DATE AND HOUR OF DEATH
2/11/70 2 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Jewish Convalescent Home
90 Pall Mall Rd. | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 1547
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3007 Elgin Av. | | | |
| 5. SEX
M | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
M | 8. DATE OF BIRTH
3/3/00 | 9. AGE (In years lost birthday)
69 | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
musician | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Jefferson Smith | | 14. MOTHER'S MAIDEN NAME
unknown | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was (Deceased) Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Wife (Rachel L. Smith) | |
| 18. 412.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Ventricular Asystole due to
Hypertensive + arteriosclerotic
heart disease with
uremia. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
unknown | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1965 to 2/11 19 70 .
that (I) (we) last saw the deceased alive on 2/11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
D. W. STEWART | | M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
2/11/70 | |
| 23C. PHYSICIAN'S NAME (Type)
D. W. STEWART | | 23D. ADDRESS
2300 Garrison Blvd. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2-14-70 | | 24C. NAME OF CEMETERY or CREMATORY
ARBUTHUS MEM. PARK BALTO. Md. | |
| 24D. LOCATION (City, town, or county) (State)
BALTO. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
William Webb | | ADDRESS
3613 DANNLYN Rd. | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|--|---|--|--|--|
| H-321 | | 70 1701 | | 70 1701 | |
| 1. NAME OF DECEASED
(Type or Print) <i>Elizabeth Hedgepeth</i> | | | 2. DATE AND HOUR OF DEATH
<i>2-11-70</i> <i>2:40</i> <i>P.M.</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>90 Pleasant Manor Convalescent Center</i> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MD</i> B. COUNTY <i>2802</i> | | |
| 5. SEX <i>Female</i> 6. RACE <i>Negro</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH <i>12/26/12</i> 9. AGE (In years last birthday) <i>57</i> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 11. BIRTHPLACE (State or foreign country) <i>Va</i> | | |
| 13. FATHER'S NAME <i>H.S. Grant Shelton</i> | | | 14. MOTHER'S MAIDEN NAME <i>Eliza V. Quarles</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT <i>Alma Reed</i> | | | ADDRESS <i>4500 Carlew Rd</i> | | |
| 18. <i>412.2 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Uremia</i>
(B) <i>Hasco to CHF + Renal Insufficiency</i>
(C) <i>Insufficiency</i> | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 mos</i>
<i>2-3 yrs.</i> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/11</i> 19 <i>70</i> to <i>2/11</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Eliza Saunders</i> | | | | 23B. DATE SIGNED <i>2/11/70</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>ELIJAH SAUNDERS</i> | | | | 23D. ADDRESS <i>2300 Garrison Blvd. Balto, MD</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/14/70</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i> | |
| 24D. LOCATION (City, town, or county) <i>Balto. MD</i> | | 24E. FUNERAL DIRECTOR <i>Joseph J. Locks</i> | | ADDRESS <i>1304 N. Central Ave</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 13 1970</i> | | 25B. NAME OF REGISTRAR <i>Robert E. [unclear]</i> | | 25C. NAME OF REGISTRAR <i>Joseph J. Locks</i> | |

1951

2

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

S-51270

1702

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1702

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
WILBERT WILLIAM SIMPSON | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour
2 9 70 2:50 PM | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
321 E. 28th Street | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
February 9, 1970 2:50 p.m. | |
| 6. SEX
Male | | 7. RACE
Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
1-2-15 | | 10. AGE (In years last birthday)
55 | |
| 11. BIRTHPLACE (State or foreign country)
CHester, S. C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
BUT. SIMPSON | | 14. MOTHER'S MAIDEN NAME
Lily McCLANTON | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Roofing | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
YES 11/1942-26/45 | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
MOSES SIMPSON | | ADDRESS
713 E. 23rd ST | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
412.41 | | CAUSE OF DEATH
Arteriosclerotic cardiovascular disease | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
YES | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Isidore Mihalakis, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED
2/10/70 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/13/70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Balto. National | | 24D. LOCATION (City, town, or county) (State)
5501 Frederick Ave | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
John E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
Joseph H. Rocks | | ADDRESS
1304 N. Central Ave | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>70 1703</u> |
|---|---------------------|--|------------------------------------|--|
| L-520 70 1703 | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Lillian M. Long</u> | | 2. DATE AND HOUR OF DEATH
<u>2/8/70</u> <u>2</u> <u>180</u> <u>P</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>34 Bon Secours Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>3811 GARRISON Blvd.</u> | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2-26-05</u> | 9. AGE (in years last birthday) <u>64</u>
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>New York</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Edwin W. Skoglin</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>Lillian Tracey</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | |
| 16. SOCIAL SECURITY NO.
<u>219-44-6728</u> | | 17. INFORMANT
<u>I. David Long 3811 GARRISON Blvd.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>412.4 I</u>
<u>Chronic arrest</u>
<u>Ascvd c av block.</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>3 days.</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-6-70</u> to <u>2-8-70</u> that (I) (we) last saw the deceased alive on <u>2-8-70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Varah Vorasubin, M.D.</u> | | 23B. DATE SIGNED
<u>2-8-1970</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>VARAH VORASUBIN, M.D.</u> | | 23D. ADDRESS
<u>Bon Secours Hosp. Balto, Md.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>2-11-70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>WOODLAWN CEMETERY</u> |
| 24D. LOCATION (City, town, or county) (State)
<u>BALTO, MD.</u> | | 25A. DATE RECEIVED BY HEALTH DEPT. <u>FEB 13 1970</u> | | |
| 25B. NAME OF FUNERAL DIRECTOR
<u>WITZKE HOWARD</u> | | 25C. ADDRESS
<u>ELICOTT CITY MARYLAND</u> | | |

2. 1941
1941-1942
1942-1943
1943-1944
1944-1945

1941-1942
1942-1943
1943-1944
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1944-1945

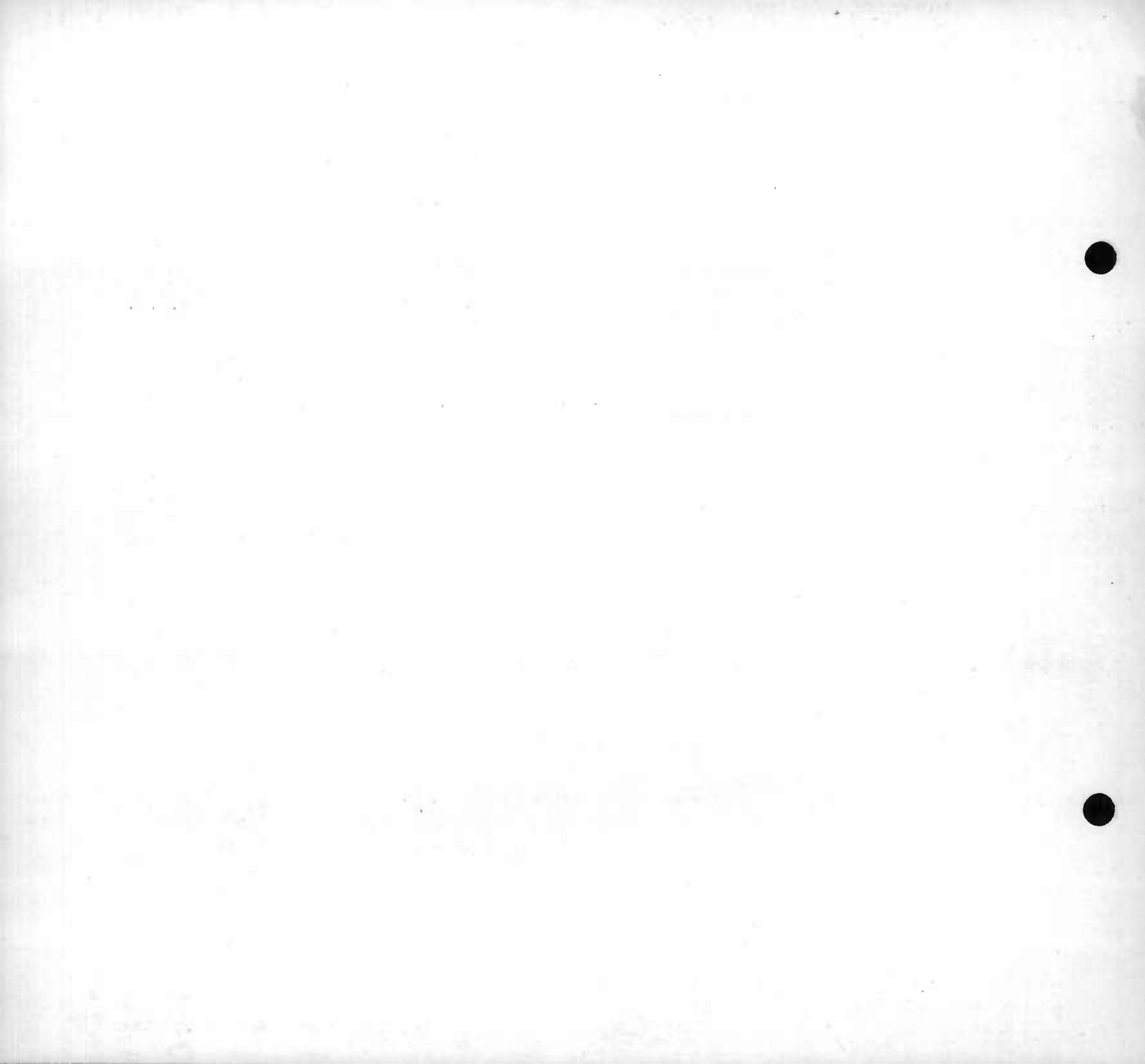
1941-1942
1942-1943
1943-1944
1944-1945

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-152 70 1704 | | | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. 70 1704 | |
|--|-------------------------|---|------------------------------------|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) LEO P. SPENCER | | | | 2. DATE AND HOUR OF DEATH
2/12/70 1:45 AM. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

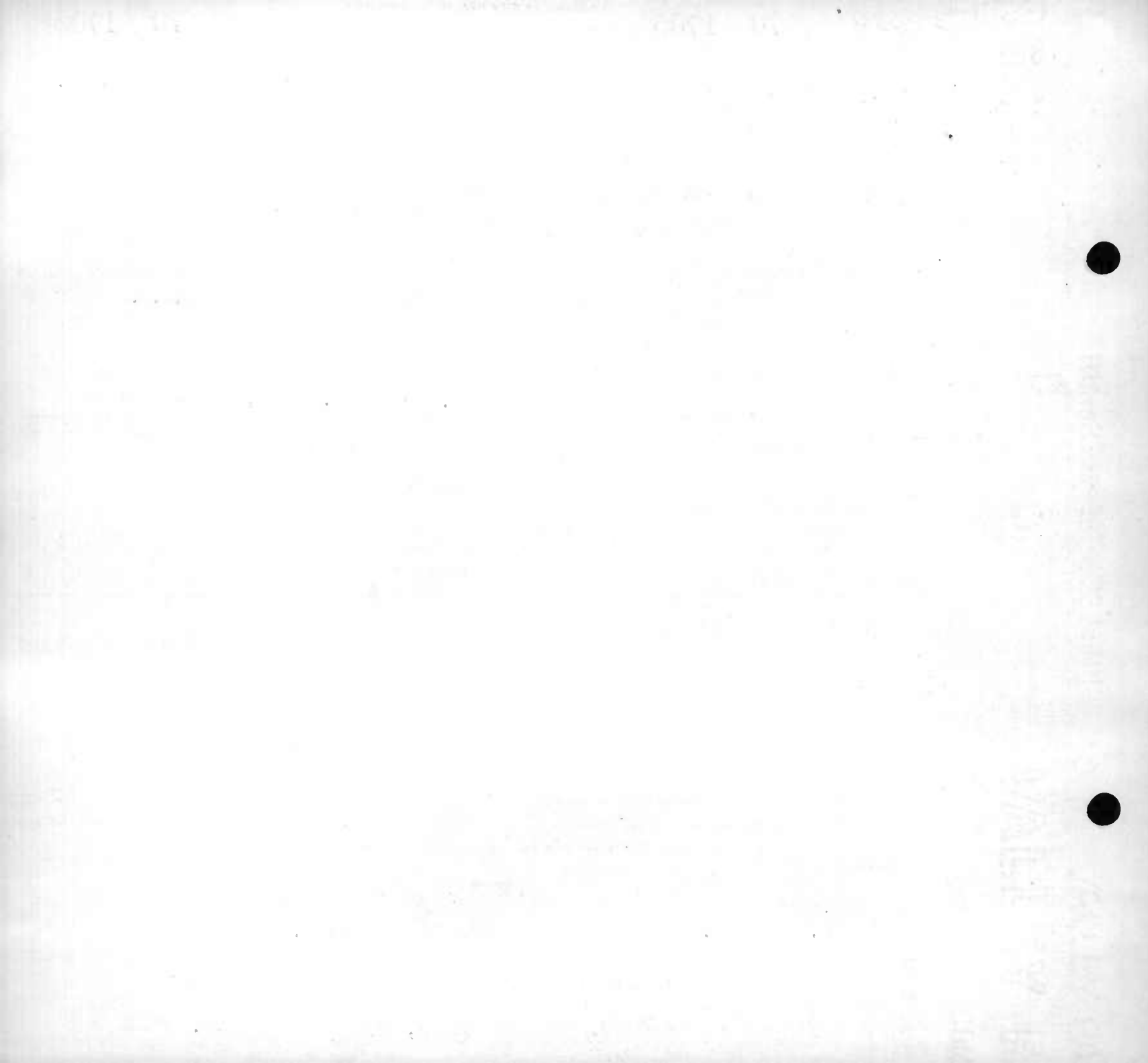
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Lutheran Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD.
B. COUNTY 2834
C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1021 COOKS LANE | | | |
| 5. SEX
Male | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-17-09 | | 9. AGE (In years last birthday)
60 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Schmidt Baking Co | | 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WWII | | 16. SOCIAL SECURITY NO.
104-07-0490 | | 17. INFORMANT ADDRESS
Mrs. Leo Spencer, 1021 Cooks Lane | | | |
| 18. 4/10/9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Cardiac Failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
Myocardial Infarction. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
39 hrs | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/10/1970 to 2/12/1970 , that (I) (we) last saw the deceased alive on 2/12/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Subash C. Ahuja MD | | | | 23B. DATE SIGNED
2/12/70 | | 23C. PHYSICIAN'S NAME (Type)
SUBASH C. AHUJA, MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/14/70 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor MD | | 25C. FUNERAL DIRECTOR
Witzke, 1630 Edmondson Ave., 21228 | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

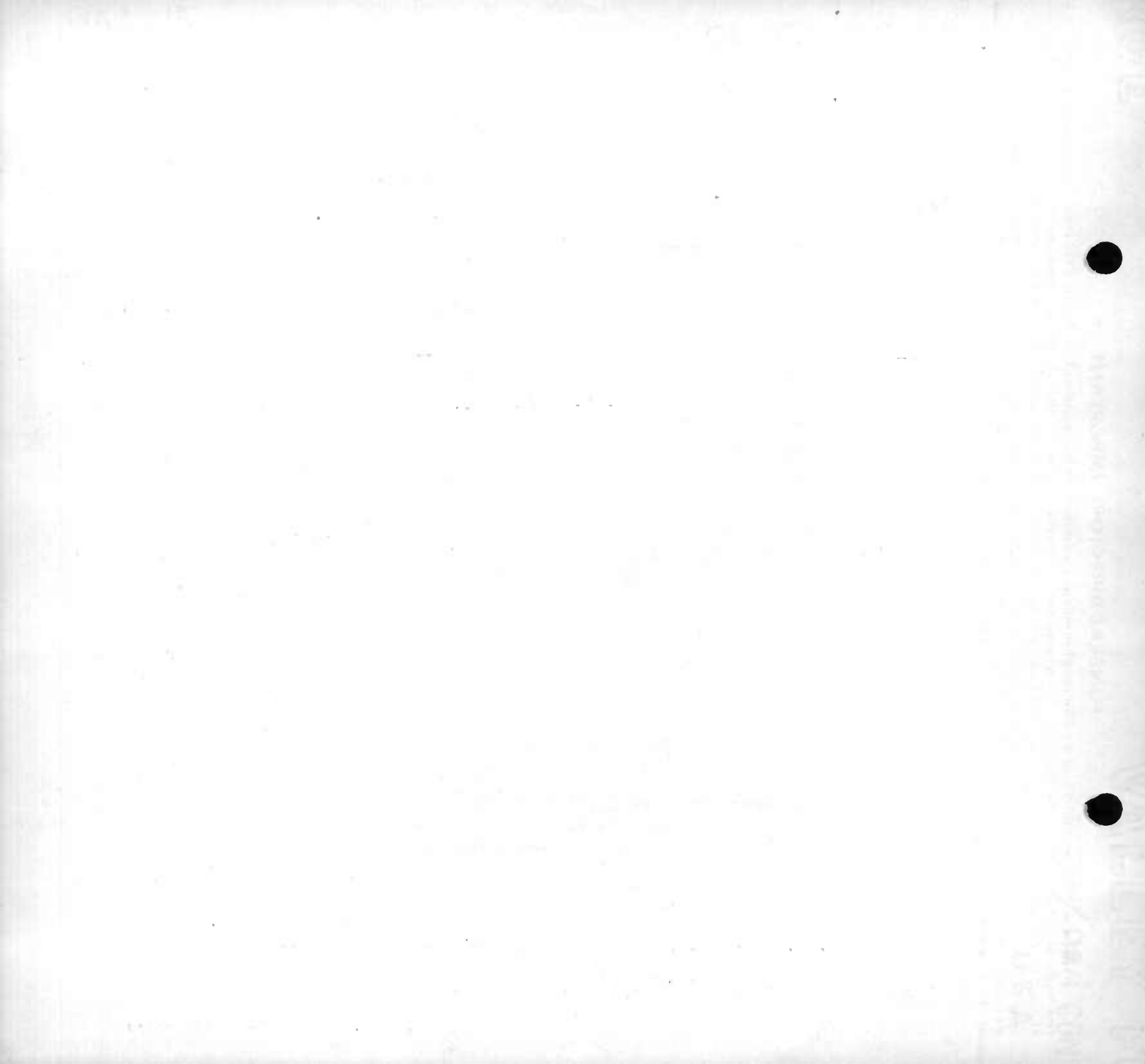
| F-400 70 1705 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1705 | |
|--|--|--|--|--|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Charles Foyle | | 2/11/70 4:30p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| 00 514 Glen Allen Drive Apt A | | | | Md | | 2834 | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| Male | | | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | | | Navy Inspector | | Pennsylvania | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| William Foyle | | | | Ella Fitzgerald | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | | | Mrs. Charles E. Foyle, 514 Glen Allen Dr | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 10 yrs | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | 15 yrs | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) EMPHYSEMA | | 10 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan - 15 19 55 to Feb 11 19 70, that (I) (we) lost saw the deceased alive on Feb 10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Dr. Norman R. Kleiman | | | | 2/12/70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Dr. Norman R. Kleiman | | | | 3803 Edmondson Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | | | 2/14/70 | | New Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| Baltimore, Maryland | | | | FEB 13 1970 | | W. J. Z. 7, 1630 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 13 1970 | | | | W. J. Z. 7, 1630 | | Edmondson Ave. 21228 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|-------------------------|---|--|--|--|
| 70 1706 | | 70 1706 | | 70 1706 | |
| BIRTH NO. <u>10-265</u> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Charles Nazeranus | | | 2. DATE AND HOUR OF DEATH
2/11/70 10-30 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 317 Yale Ave. | | | A. STATE Md
B. COUNTY 2541 | | |
| | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER 317 Yale Ave. | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/19/82 | 9. AGE (In years last birthday)
87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
215-07-6125A | | 17. INFORMANT ADDRESS
Mrs. Evelyn Brackbill, 9521 Pepple Drive |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Coronary Occlusion
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Cardio-Vascular Disease | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Coronary Occlusion
(B) Cardio-Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF:
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden
10 years |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/5 19 70 to 2/11 19 70 , that (I) (we) last saw the deceased alive on 2/9 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. W. Johnson | | | | 23B. DATE SIGNED
2/12/70 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. E. W. Johnson | | 23D. ADDRESS
3432 Frederick Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/14/70 | | 24C. NAME of CEMETERY or CREMATORY
Lorraine Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR
Witzke, Inc. | | 25D. ADDRESS
1630 Edmondson Ave., 21228 | |



| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 6. SEX | | 7. RACE | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. CITY OR TOWN | | 10. INSIDE CITY LIMITS? | |
|--|--|--|--|--|--|--|--|---|--|---|--|-------------------------|--|---|--|-----------------|--|---|--|
| JAMES WHEATLEY | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year | | February 11, 1970 | | Hour M. | | Male | | White | | | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | Month Day Year | | February 11, 1970 | | 3:55 P. M. | | | | | | | | | | | |
| St. Agnes Hospital | | (DOA) | | | | | | | | | | | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT | | ADDRESS | | | |
| Maryland | | U.S.A. | | Harry D. Wheatley | | Retired | | Agnes Clarson | | no | | 217-14-5515 | | Mrs. James Wheatley, 14 Maple Ave. | | | | | |
| 19. 412.4 I | | CAUSE OF DEATH | | Arteriosclerotic cardiovascular disease | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE | | | | | | | | | | | |
| | | | | | | (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | |
| | | | | | | ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | |
| | | | | | | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (C) _____ | | | | | | | | | | | |
| | | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | | | | | | | | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED | | 22F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | | | |
| OF INJURY (APPROX.) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 23. | | | | | | | | | | | | | | | | | | | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | | | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | | | | | | | | | | | |
| Burial | | 2/14/70 | | New Cathedral Cemetery | | Baltimore, Maryland | | | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | | | | | | | | | | | |
| FEB 13 1970 | | Robert E. Taylor, R.D. | | Witzke, 1630 Edmondson Ave., 21228 | | | | | | | | | | | | | | | |

ACADEMY HOME

WILKINSON

WILKINSON

WILKINSON

WILKINSON

WILKINSON

WILKINSON

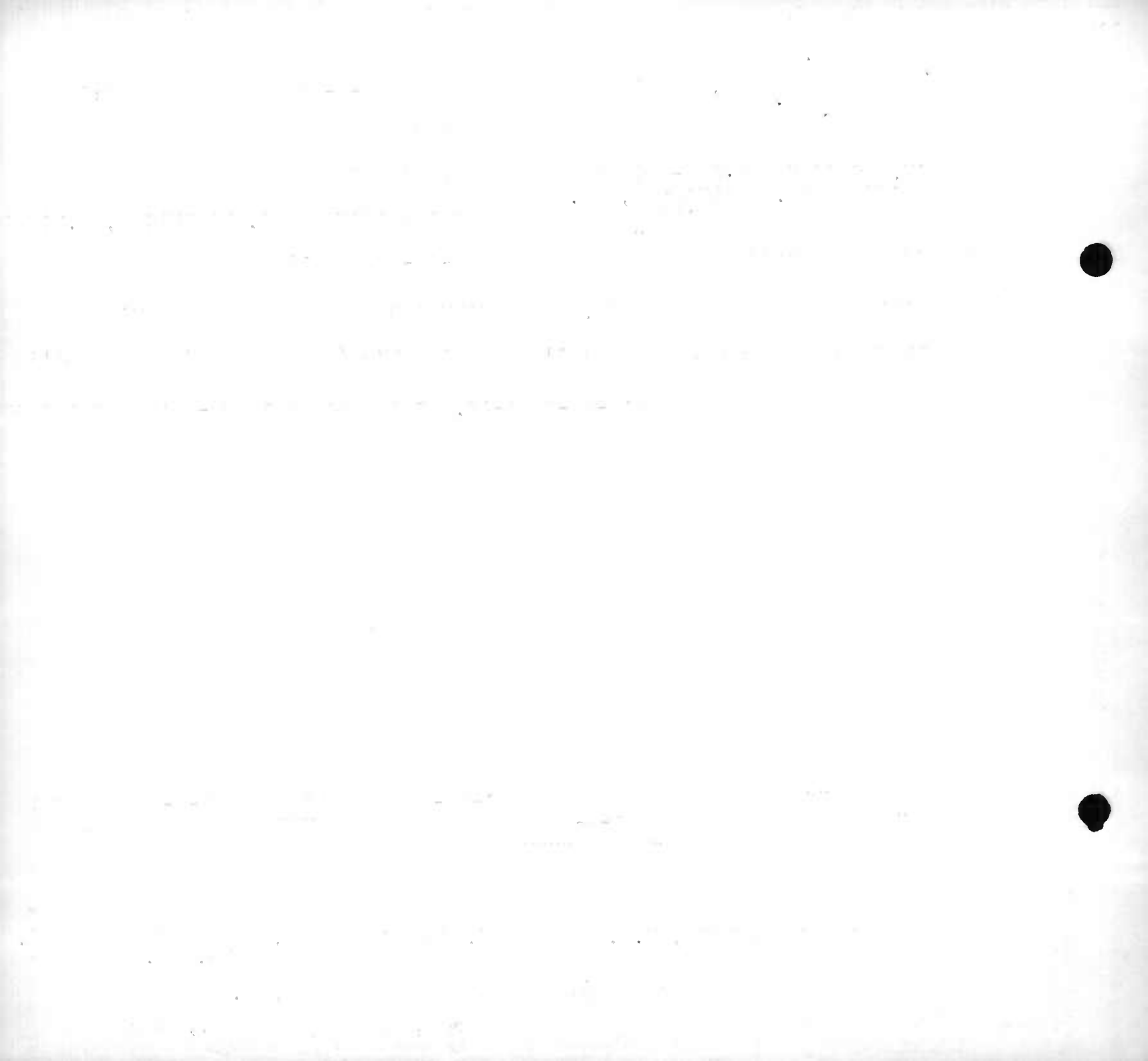
WILKINSON

WILKINSON

WILKINSON

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|------------------------------|
| S-165 70 1708 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1708 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | SAFFRAN, BESSIE | | 2. DATE AND HOUR OF DEATH
2-9-70 12:10 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY | | 5. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | MARYLAND | | BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| ST. AGNES HOSPITAL - WILKENS & CATON AVE., BALTIMORE, MD. 21228 | | 533 PRITCHARD DR. LINTHICUM, MD. 21090 | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| FEMALE | WHITE | | 09-18-95 | 74 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETIRED | | PAPER CO. | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| ZEPHANIAH Duckworth | | CAROLYN () | | NO | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 218-16-3891 | | ST. AGNES RECORD ROOM - WILKENS & CATON | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 412.4 I | | Cerebral Thrombosis | | | |
| ANTECEDENT CAUSES | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | ASCVD | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | Bilateral Pneumonia | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 1-26-1970 to 2-9-1970 that (1) (we) last saw the deceased alive on 2-9-70 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| George Patrick, M.D. | | 2-9-70 | | ST. AGNES HOSPITAL, WILKENS & CATON AVE. BALTO MD 21228 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 2/12/70 | New Cathedral Cemetery | Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 13 1970 | John E. Taber, Jr. | Witzke, 1630 Edmondson Ave., 21228 | | | |



PCM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| W-160 70 1709 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1709 | |
|--|------------------|--|------------------------------|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) WEBER, HARRY W. | | 2. DATE AND HOUR OF DEATH
6:30 A.M.
2-12-70 -9-20-A- M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL
WILKENS & CATON AVE.
BALTIMORE, MD. 21228
2-17-70 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 820 COOKS LANE BALTO MD. | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
07-09-91 | 9. AGE (in years last birthday)
78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MECHANIC-RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY
STANDARD OIL | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
WALTER WEBER DEC 'D | | 14. MOTHER'S MAIDEN NAME
MINNIE ROWLENSON DEC 'D | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
213-05-8296 | | 17. INFORMANT
ADDRESS
CATON AVE.
ST. AGNES RECORD ROOM - WILKENS & | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Bronchogenic Carcinoma
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Pulmonary Emphysema | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 1-19 19 70 to 2-12 19 70 that (X) (we) last saw the deceased alive on 2-12 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) did (X) (not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | 23B. DATE SIGNED
02 12 70 | | 23C. PHYSICIAN'S NAME (Type)
SALVADOR QUIROZ | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/14/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Siloan Cemetery | |
| 24D. LOCATION
Siloan, Maryland | | 24E. NAME OF REGISTRAR
Witzke | | 24F. FUNERAL DIRECTOR
Edmondson Ave., 21229 | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Witzke | | 25C. FUNERAL DIRECTOR
Edmondson Ave., 21229 | |

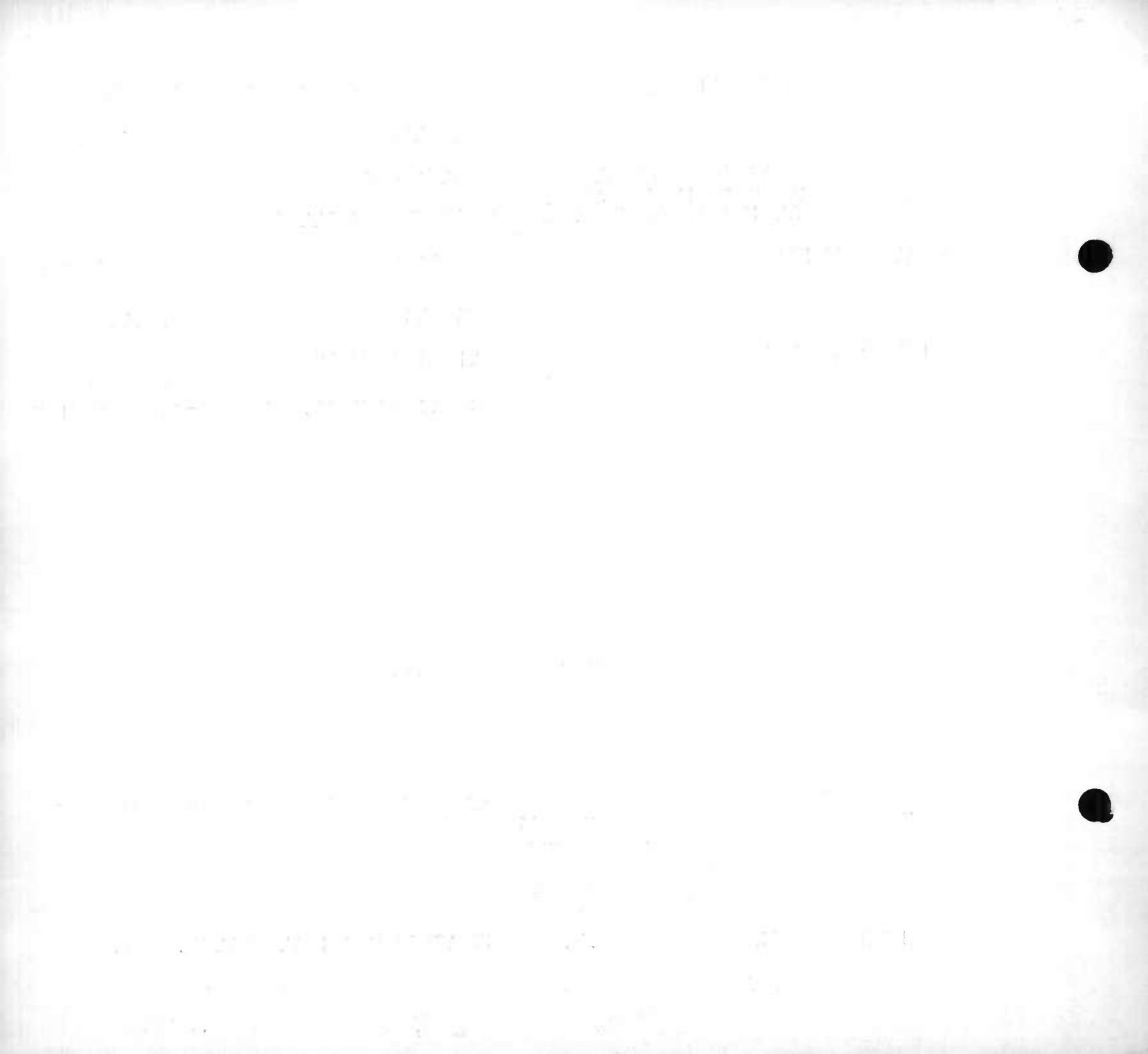
V.S. 153 2-17-70 M.H.
Letter from St. Agnes Hospital for
hour of death.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 70 1710 | |
|---|--|--|--|--|--|
| BIRTH NO. F-160 70-02832 1710
1. NAME OF DECEASED
(Type or Print) FABER, LISA ANN | | 2. DATE AND HOUR OF DEATH
FEBRUARY 11, 1970 5:41 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

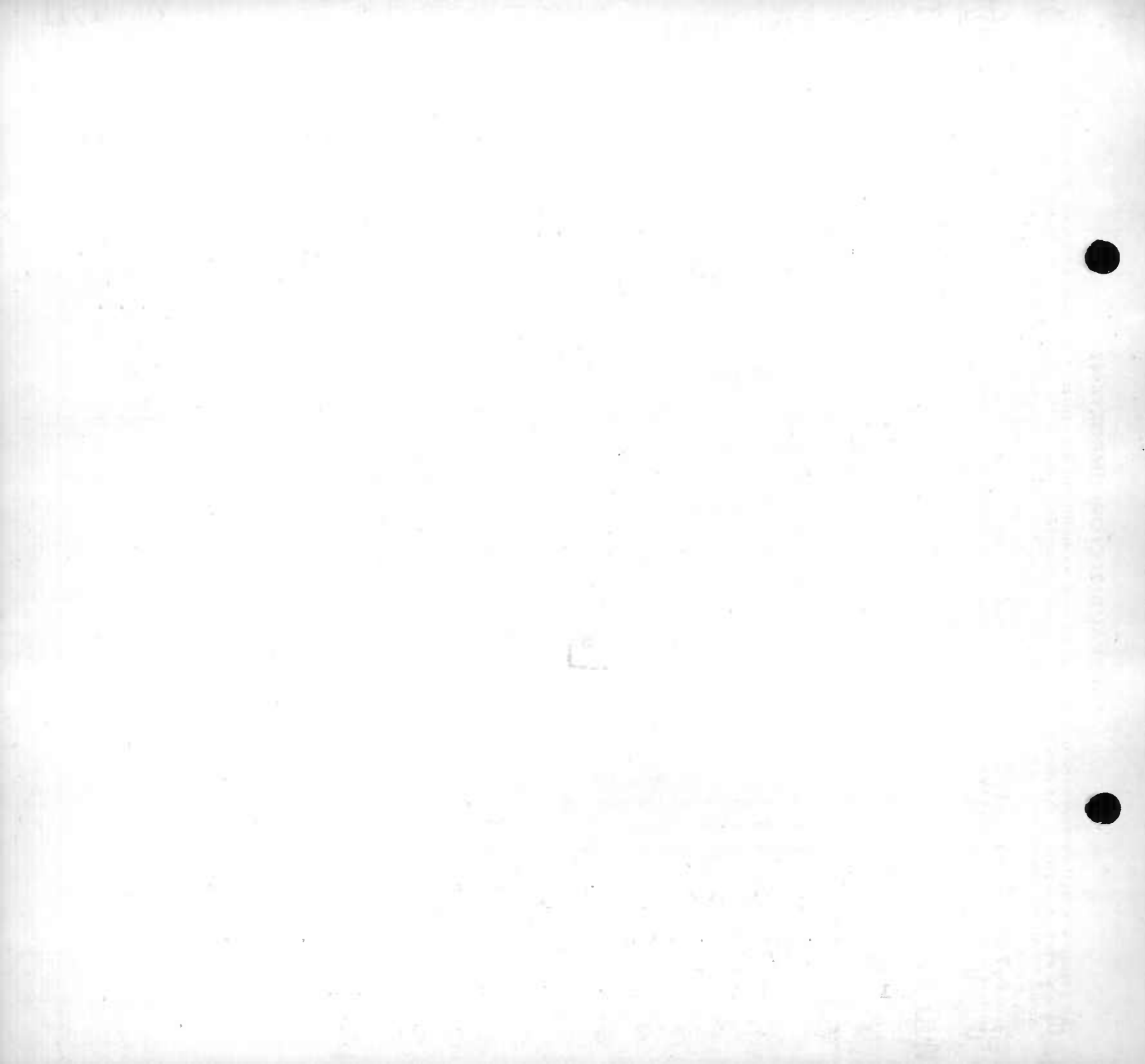
FULL NAME OF HOSPITAL OR INSTITUTION
40 ST AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MARYLAND 21228 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY BALTO. CO.
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 21228 5300 214 CHERRYDELL RD | | | |
| 5. SEX FEMALE 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 02 11 70 9. AGE (In years last birthday) 1 29 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME
TIMOTHY C FABER | | | | 14. MOTHER'S MAIDEN NAME
LINDA (DOWNEY) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ST AGNES HOSP. RECORDS-CATON & WILKENS ADDRESS AVES BALTO MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH CONGENITAL ANOMALY
A) ANAPHYLACTIC
B) SPINA BILIDA
(Mother had Kell Antibody)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 11 1970 to FEBRUARY 11 1970 that (I) (we) last saw the deceased alive on FEBRUARY 11 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (d) (d) (d) view the body after death. | | | | | |
| 23A. SIGNATURE
Richard Buyalos | | | | 23B. DATE SIGNED 12 Feb 70 | |
| 23C. PHYSICIAN'S NAME (Type)
RICHARD BUYALOS, M.D. | | 23D. ADDRESS ST AGNES HOSPITAL, BALTO., MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/13/70 | | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 13 1970 25B. NAME OF REGISTRAR Jabari E. Bailey | | | |
| 25C. FUNERAL DIRECTOR WILKES, 1630 Edmondson Ave., 21228 | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

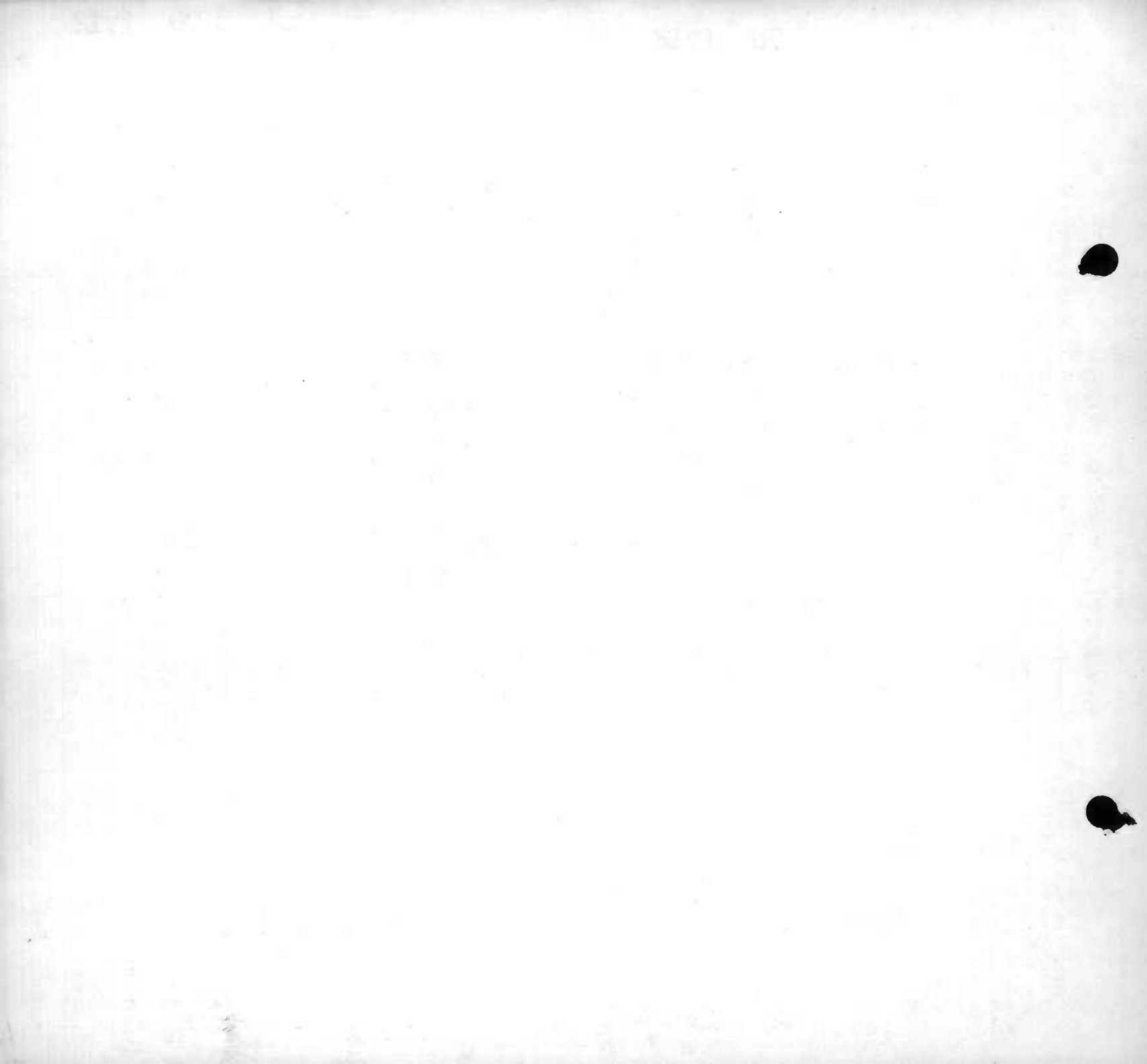
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1711 | | 70 1711 | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Alvin Lloyd | | | | 2/11/70 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 40 St. Agnes Hospital | | | | Md Howard Co. 63-00 | | | |
| 5. STREET AND NUMBER | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | | | |
| 8417 Westgrove Road | | | | Ellicott City YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 6. SEX | | 7. RACE | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. DATE OF BIRTH | |
| Male | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9/22/89 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired | | | | New York | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Simon Lloyd | | | | Sarah | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| unknown | | | | 17. INFORMANT ADDRESS | | | |
| | | | | Clyde Redding, 8417 Westgrove Road | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CARCINOMATOSIS 8 Mo | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | CARCINOMA - PANCREAS 1 yr | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 15 1969 to Feb 11 1970, that (I) (we) last saw the deceased alive on Feb 9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Dr. Norman R. Kleiman | | | | 2/12/70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Dr. Norman R. Kleiman | | | | 3803 Edmondson Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2/16/70 | | Glen Haven Cemetery | | Glen Burnie Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 13 1970 | | Robert E. Taylor, Jr. | | Witzke, 4101 Edmondson Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1712 | |
|--|--|--|---|---|---|
| BIRTH NO. 70 1712 | | 70 1712 CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) DUNTON, JOYCE. E | | | 2. DATE AND HOUR OF DEATH
2-8-1970 10:05 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTO. CO. 5300 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
LUTHERAN HOSPITAL OF MARYLAND
46 730 ASHBURTON ST. BALTIMORE MD. 21216 | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX FEMALE 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
10-28-39 | | 9. AGE (In years last birthday) 30 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
JAMES Thornton | | | 14. MOTHER'S MAIDEN NAME
Martina | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
219-38-9555 | | 17. INFORMANT 6712 Kinchelow Ave. Raymond N. Dunton ADDRESS 21207 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
753.151/1970
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF:
POLYCYSTIC KIDNEYS & Adeno-Carcinoma
& Metastasis to Lungs. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-25-1970 to 2-8-1970 , that (I) (we) last saw the deceased alive on 2-8-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Prem Lal M.B.B.S. | | | 23B. DATE SIGNED | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)
PREM LAL, M.B.B.S. | | | 23D. ADDRESS LUTHERAN HOSPITAL 730 ASHBURTON ST. BALTIMORE MD. 21216 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-12-70 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus Memorial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Marshall W. Jones, Jr. 1735 Harford Ave. 21213 |



1
5-520

70 1713

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1713

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT JONES, JR.

2. DATE OF DEATH Known ☐ Estimated ☐ Month Day Year Hour M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

800 E. 41st St.

3. DATE PRONOUNCED DEAD Month Day Year Hour M.
2 9 70 12:45 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 901

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH
5-5-1927

10. AGE (In years last birthday)
42

11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

800 E. 41st St.

11. BIRTHPLACE (State or foreign country)
North Carolina

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Robert Jones, Jr.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Carrie Jones

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
yes W.W.II

17. SOCIAL SECURITY NO.
213-20-1212

18. INFORMANT 800 E. 41st St. ADDRESS
Mrs. Carrie Jones

19. E887 X 1

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Subdural hemorrhage
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Epilepsy

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes (head)

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Unk.

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
Unk.

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)
Unk.

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ (head)

22F. HOW DID INJURY OCCUR?
Presumably fell and struck head.

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-9-70

24A. BURIAL CREMATION, REMOVAL (Specify)
Burial

24B. DATE
2-13-70

24C. NAME OF CEMETERY or CREMATORY
Baltimore National

24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970

25B. NAME OF REGISTRAR
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR 1735 Harford Road, 21213
Marshall W. Jones, Jr.

W-426 70 1714 BALTIMORE CITY HEALTH DEPARTMENT X
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 1714

| | | | | | | | |
|---|---------|---|--|---|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year Hour | |
| | | WILLIAM WALKER | | | | M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 3. DATE PRONOUNCED DEAD | | Month Day Year Hour | |
| ST. AGNES HOSPITAL | | | | February 10, 1970 | | B:30 P. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | | B. COUNTY | | | |
| Virginia | | Virginia | | V-43 | | | |
| 6. SEX | 7. RACE | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| Male | Negro | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Alexandria | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | 10. AGE (In years lost birthday) | | E. STREET AND NUMBER | | | |
| 4/1/1938 | | 31 | | 328 N. Patrick Street | | | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | | |
| VIRGINIA | | U.S.A. | | WILLIAM WALKER | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME | | | |
| | | | | VIRGINIA DAVENPORT | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT | | ADDRESS | |
| | | | | VIRGINIA DAVENPORT | | 328 N. Patrick St. Alexandria Va. | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| E81510 | | Gastrointestinal hemorrhage | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | (B) Duodenal ulcer complicating fracture of neck
DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | (C) | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | | |
| | | | | yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If In Baltimore City, give exact location) INJURY OCCUR? | | | |
| | | Street | | Interstate Rt. 295-2640 ft. N. of State Rte 175 | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | | | |
| 1-18-70 7:15 A. | | | | Driver in auto fixed object collision | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER | | 2/11/70 | | | |
| Ronald N. Kornblum, M.D. | | ASSOCIATE MEDICAL EXAMINER | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| REMOVAL | | 2/11/70 | | COLEMAN CEM | | FAIRFAX Co. Va | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 19 1970 | | Robert E. Taylor, M.D. | | E. Roy O. Wilson | | 1000 BRANTLEY AVE | |

NO 1714

RECEIVED BY THE DEPT. OF DEATH

NO 1714

ACADEMY DOND

ALPHABETICALLY

ALPHABETICALLY

U

N

C

N

FEB 13 1970 Robert E. Roberts, Jr. *Elmer Roberts on 1007 Brantly Ave*
VS 151-REV. 7/1/68

ACADEMIC BOND

FACE VALUE

WILLIAM PAPER CO

NEW YORK

1914

1914

1914

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 1716

| | | | | | |
|--|---------------------------|---|---|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Sabelle Stewart</u> | | 2. DATE AND HOUR OF DEATH
<u>2/11/70</u> <u>8:30 PM</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>1802</u> | | C. CITY OR TOWN <u>Balti.</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNIVERSITY of MD HOSP.</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
<u>1096 W. Fayette St</u> | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 4, 1891</u> | 9. AGE (In years lost birthday)
<u>78</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Char woman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Balti. Md</u> | |
| 13. FATHER'S NAME
<u>Henderson Williams</u> | | 14. MOTHER'S MAIDEN NAME
<u>Jane. ?</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Harold Williams 3211 Howard Park Ave</u> | |
| 18. <u>436.01</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
<u>Cardiac Arrhythmia</u>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Hypertension</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<u>Cerebral Blood Accident</u>
(C) <u>Cachexia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/11/70</u> 19 to <u>2/11/70</u> 19 that (I) (we) last saw the deceased alive on <u>2/11/70</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Andrew R. Schwenker</u> | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>2/11/70</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Andrew R. Schwenker</u> | | 23D. ADDRESS
<u>University Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/17/70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Cover Memorial Park</u> | |
| 24D. LOCATION
<u>Laurel Md</u> | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 13 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. J. Jones, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Williams Funeral Home 3197 Snowden St</u> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1717

BIRTH NO.

| | | | | | | | |
|---|--|---|--|---|-----|--|-----------|
| 1. NAME OF DECEASED
(Type or Print)
Santo Cutugno | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | | Month | Day | Year | Hour |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Hopkins Hospital | | 3. DATE PRONOUNCED DEAD | | Month | Day | Year | Hour |
| | | | | 2 | 7 | 70 | 1:30 p.m. |
| 6. SEX
male | | 7. RACE
white | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Rising Sun | |
| 9. DATE OF BIRTH
AUG. 25, 1926 | | 10. AGE (in years last birthday)
43 | | 11. BIRTHPLACE (State or foreign country)
ITALY | | 12. CITIZEN OF WHAT COUNTRY?
ITALY | |
| 13. FATHER'S NAME
THOMAS CUTUGNO | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 15. MOTHER'S MAIDEN NAME
DOMENICA LONGO | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | |
| 17. SOCIAL SECURITY NO.
213-44-2246 | | 18. INFORMANT
JOSEPH ROELLO | | 19. ADDRESS
RISING SUN MD. | | 20. CAUSE OF DEATH | |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Multiple injuries | | 22. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 25. DATE OF OPERATION | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 27. AUTOPSY? (Yes or No)
yes | | 28. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
street | | 30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Hopewell Rd. near Rising Sun | | 31. HOW DID INJURY OCCUR?
pedestrian struck by car | | 32. TIME OF INJURY (APPROX.)
2 7 70 11:05 am | |
| 33. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 34. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 35. ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | 36. DATE SIGNED
2/8/70 | |
| 37. NAME (Type)
Werner U. Spitz, M.D. | | 38. NAME OF REGISTRAR
Ralph M. Reed | | 39. FUNERAL DIRECTOR
RALPH M. REED | | 40. ADDRESS
RISING SUN, MD. | |
| 41. BURIAL CREMATION, REMOVAL (Specify)
2/12/70 | | 42. NAME OF CEMETERY OR CREMATORY
ST. CATHERINE | | 43. LOCATION (City, town, or county) (State)
QUARRYVILLE PA. | | 44. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | |

10 1113

MEMORANDUM FOR THE DIRECTOR

TO : THE DIRECTOR
FROM : [illegible]
SUBJECT : [illegible]
[illegible text follows]

ADDITIONAL
PAGE CONTAINS
VALUABLE INFORMATION

[Handwritten signature]

ENCLOSURE

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

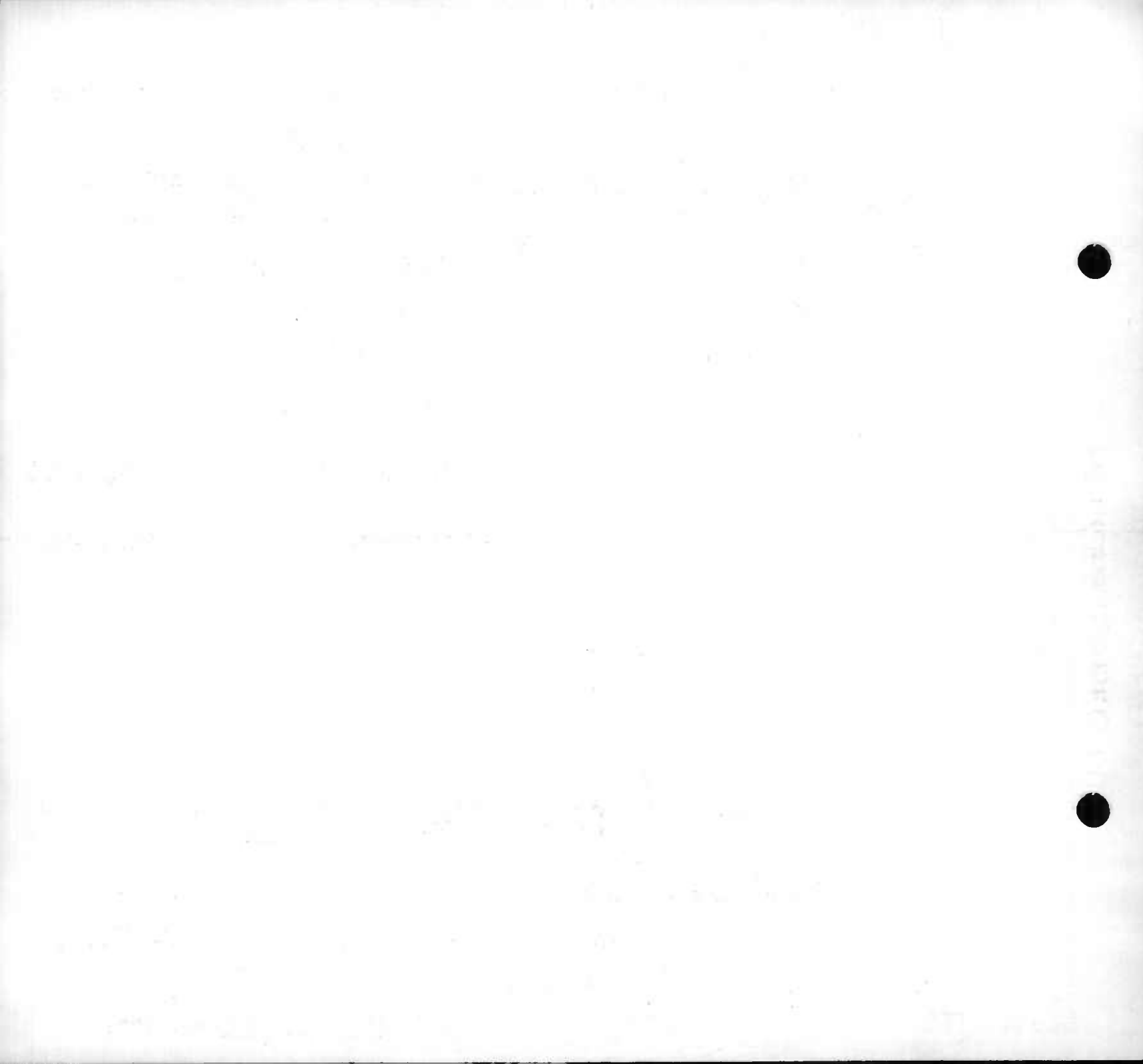
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1718 | | 70 1718 | |
|--|--|---|--|---|--|---|--|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) CHRISTY, ANNA MARIE | | | | 2. DATE AND HOUR OF DEATH
Feb. 10, 1970 8:10 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Harford Gardens Convalescent Home
4706 Harford Rd.
Baltimore, Md 21214 | | | | A. STATE
Md. 21206 | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
Fe | | | | 6. RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY
at home | | 8. DATE OF BIRTH
1/29/89 | |
| 13. FATHER'S NAME
John F. McManus | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Linton | | 9. AGE (In years last birthday)
80 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
218-09-2445D | | | | 16. SOCIAL SECURITY NO.
218-09-2445D | | 17. INFORMANT
Elizabeth Buschman, dght. above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
412.421250.9
Arteriosclerotic Cardio-vascular Disease
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Diabetes Mellitus | | | | CAUSE OF DEATH
Arteriosclerotic Cardio-vascular Disease
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Several years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Diabetes Mellitus | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Several years | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 11 19 69 to Feb 10 19 70 that (I) (we) last saw the deceased alive on Feb 9 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Loy M. Zimmerman M.D. | | | | 23B. DATE SIGNED
2/10/70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Loy M. Zimmerman M.D. | | | | 23D. ADDRESS
3202 Harford Rd. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/13/70 | | 24C. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Poley | | 25C. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc. | | ADDRESS
3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-245 70 1719 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | X REG. NO. 70 1719 | |
|---|---------------------|--|--|---|---|
| 1. NAME OF DECEASED
(Type or Print) <u>Lynn Jane Biglen</u> | | 2. DATE AND HOUR OF DEATH
<u>Feb 9, 1970</u> <u>9 A</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>2 Sinai Hospital of Baltimore</u> | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>5767 Utrecht Rd. #6</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>12/29/60</u> | 9. AGE (In years last birthday)
<u>9</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>student</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME
<u>James E. Biglen</u> | | 14. MOTHER'S MAIDEN NAME
<u>Edith</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>James E. Biglen, father, above</u> | |
| 18. <u>207.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
[This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.]
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<u>Leukemia</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>Anemia</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>9 months</u>
<u>10 weeks</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>69</u> to <u>Feb 9,</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>Feb. 6,</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Todd Gladstone, M.D.</u> | | 23B. DATE SIGNED
<u>2/9/70</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Todd Gladstone, M.D.</u> | | 23D. ADDRESS
<u>Sinai Hospital of Baltimore</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/13/70</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Oak Lawn Cemetery</u> | |
| 24D. LOCATION
<u>Baltimore, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 13 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. [unclear]</u> | | 25C. FUNERAL DIRECTOR
<u>Chrimmell Funeral Home, Inc.</u> | |
| | | | | ADDRESS
<u>3331 Brehms Lane</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

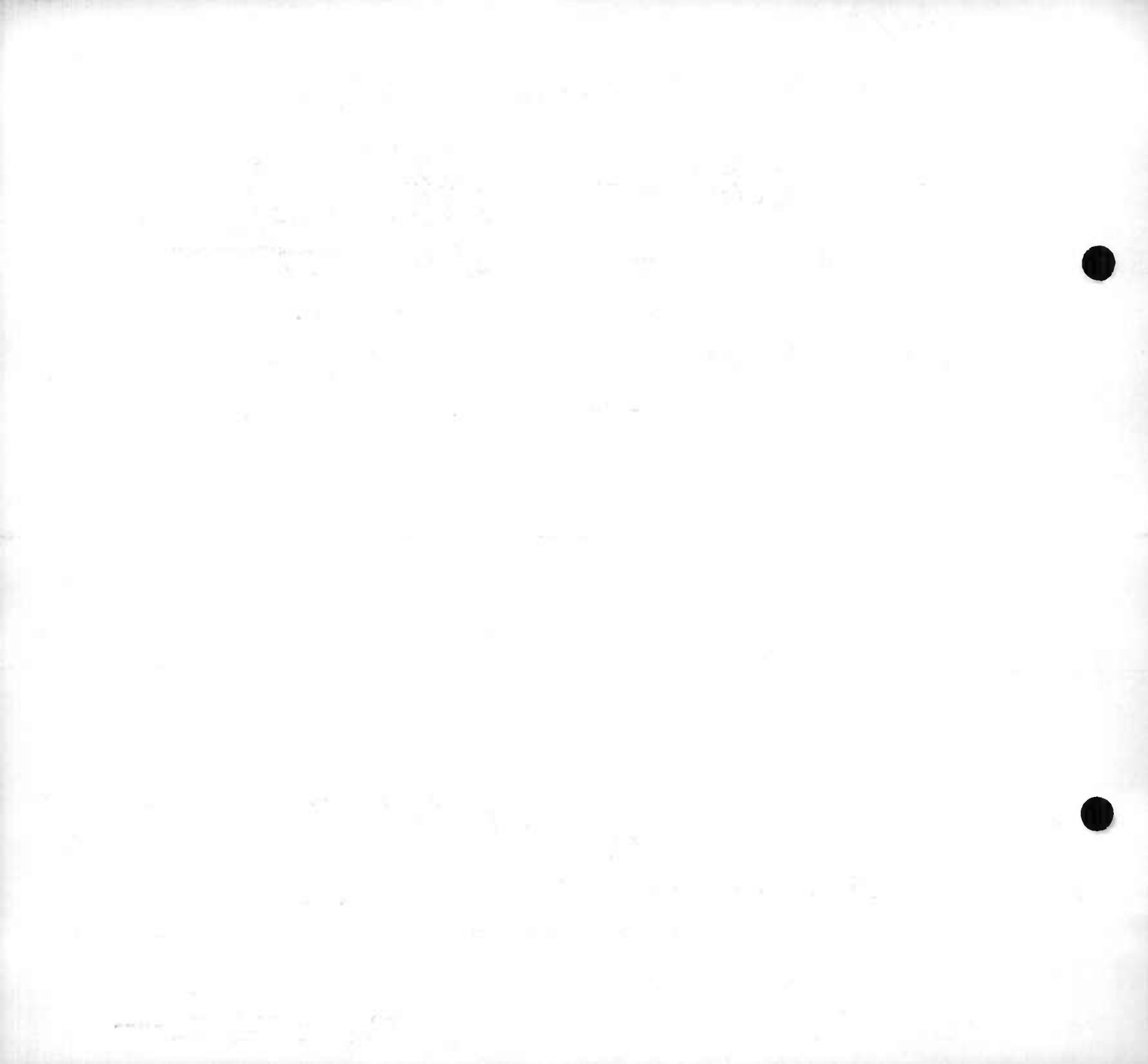
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1720</u> | |
|--|--|--|--|--|---|
| BIRTH NO. <u>S-420 70 1720</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>HENRY SILK</u> | | | 2. DATE AND HOUR OF DEATH
<u>2-9-70 4:20 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>1338</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>UNION MEMORIAL HOSP BALT., MD. 21218</u> | | | C. CITY OR TOWN
<u>BALT.</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>M</u> 6. RACE <u>CAU</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | E. STREET AND NUMBER
<u>2270 DRUID PARK DRIVE</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED Elec. Eng. Westinghouse</u> | | | 8. DATE OF BIRTH
<u>3-18-02</u> | | 9. AGE (in years last birthday) <u>67</u> |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>PATRICK SILK</u> | | | 14. MOTHER'S MAIDEN NAME
<u>GERTRUDE LEWIS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>UNKNOWN</u> | | | 16. SOCIAL SECURITY NO.
<u>132-05-4336A</u> | | 17. INFORMANT <u>Elizabeth (nee Harnig) wife, above</u> |
| 18. <u>183X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<u>SEPSIS AND UREMIA</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>OBSTRUCTIVE UROPATHY</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<u>CA OF PROSTATE</u>
(C) _____ | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-8-70</u> to <u>2-9-70</u> that (I) (we) last saw the deceased alive on <u>2-9-70</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>J. Shipper M.D.</u> | | | | 23B. DATE SIGNED
<u>2-9-70</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>J. Shipper M.D.</u> | | | | 23D. ADDRESS
<u>Schimunek Funeral Home, Inc. 3331 Brehms Lane</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/12/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Lorraine Park</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 13 1970</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Sabin, R.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Schimunek Funeral Home, Inc. 3331 Brehms Lane</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

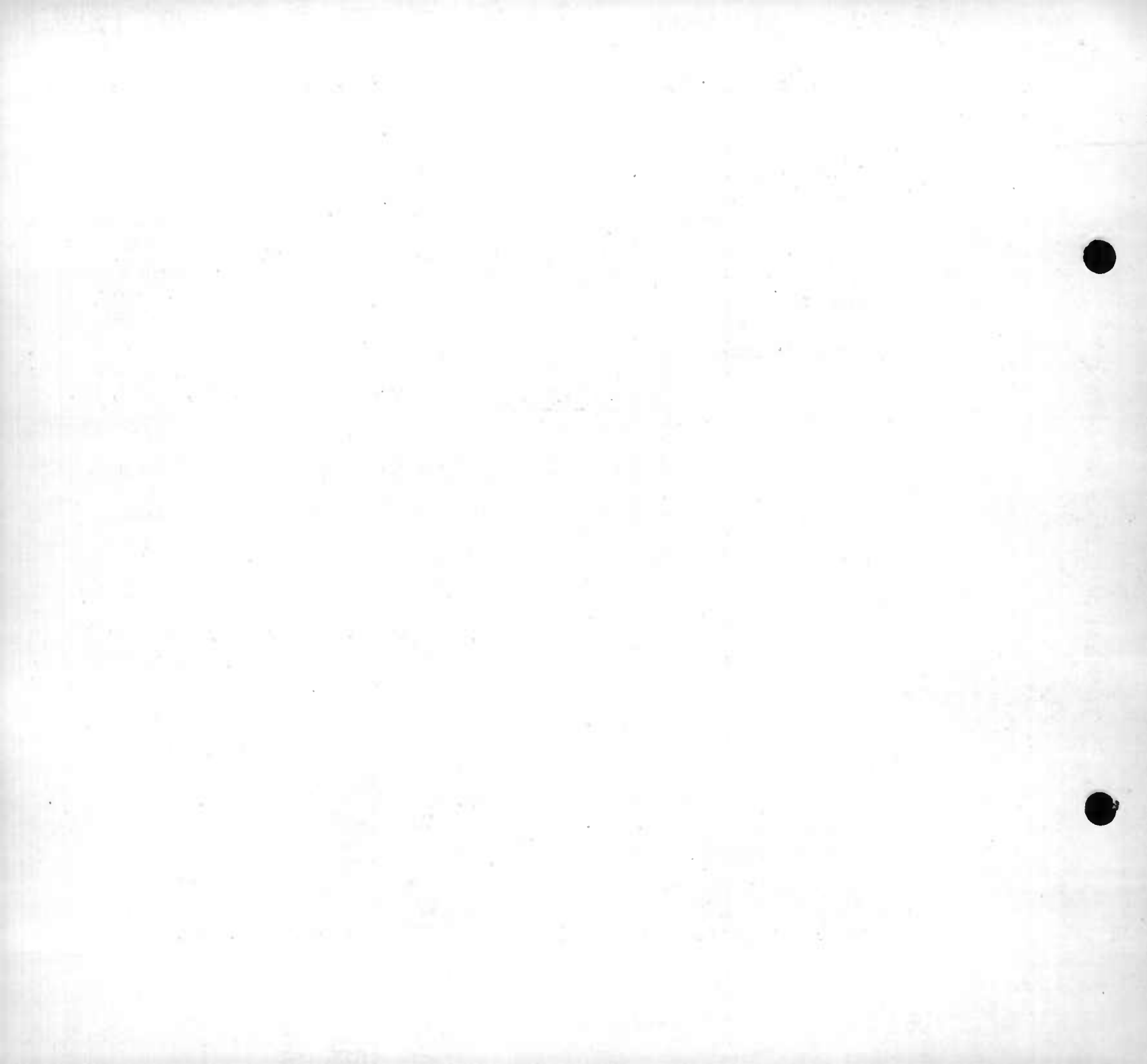
| Baltimore City Health Department | | | |
|--|--|---|--|
| H-612 70 1721 | | CERTIFICATE OF DEATH | |
| BIRTH NO. 70 1721 | | REG. NO. 70 1721 | |
| 1. NAME OF DECEASED
(Type or Print) <i>Mrs. Helen M. Harbaugh</i> | | 2. DATE AND HOUR OF DEATH
<i>2/8/70</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Bon Secours Hosp.</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>Balto. Co</i> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>2025 W. Fayette Street</i> | | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>Female</i> 6. RACE <i>W</i> | | E. STREET AND NUMBER <i>606 Bay Drive</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>6/13/05</i> 9. AGE (in years lost birthday) <i>64</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Tavern</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Md.</i> | |
| 10B. KIND OF BUSINESS OR INDUSTRY
<i>own business</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<i>John C. Sennett</i> | | 14. MOTHER'S MAIDEN NAME
<i>Nora C. Sparks</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>216-32-9370</i> | |
| | | 17. INFORMANT
<i>Mr. Wilson Sennett, 606 Bay Drive</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>410.9 + 250.9</i> | | CAUSE OF DEATH
<i>Posterior H.I. Necrosis</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Arteriosclerosis</i> | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<i>Diabetes mellitus</i> | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>hours</i> | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (i) (this hospital) attended the deceased from <i>2-8-70</i> to <i>2-8-70</i> that (i) (we) last saw the deceased alive on <i>2-8-70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>Charles Vorasubin, M.D.</i> | | 23B. DATE SIGNED
<i>2-8-1970</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>VARAH VORASUBIN, M.D.</i> | | 23D. ADDRESS
<i>Bon Secours Hosp. Balto, Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2/12/70</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY
<i>Oak Lawn Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 13 1970</i> | | 25B. NAME OF REGISTRAR
<i>John J. ...</i> | |
| 25C. FUNERAL DIRECTOR
<i>Schmunk Funeral Home, Inc.</i> | | ADDRESS
<i>3331 Brehms Lane</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

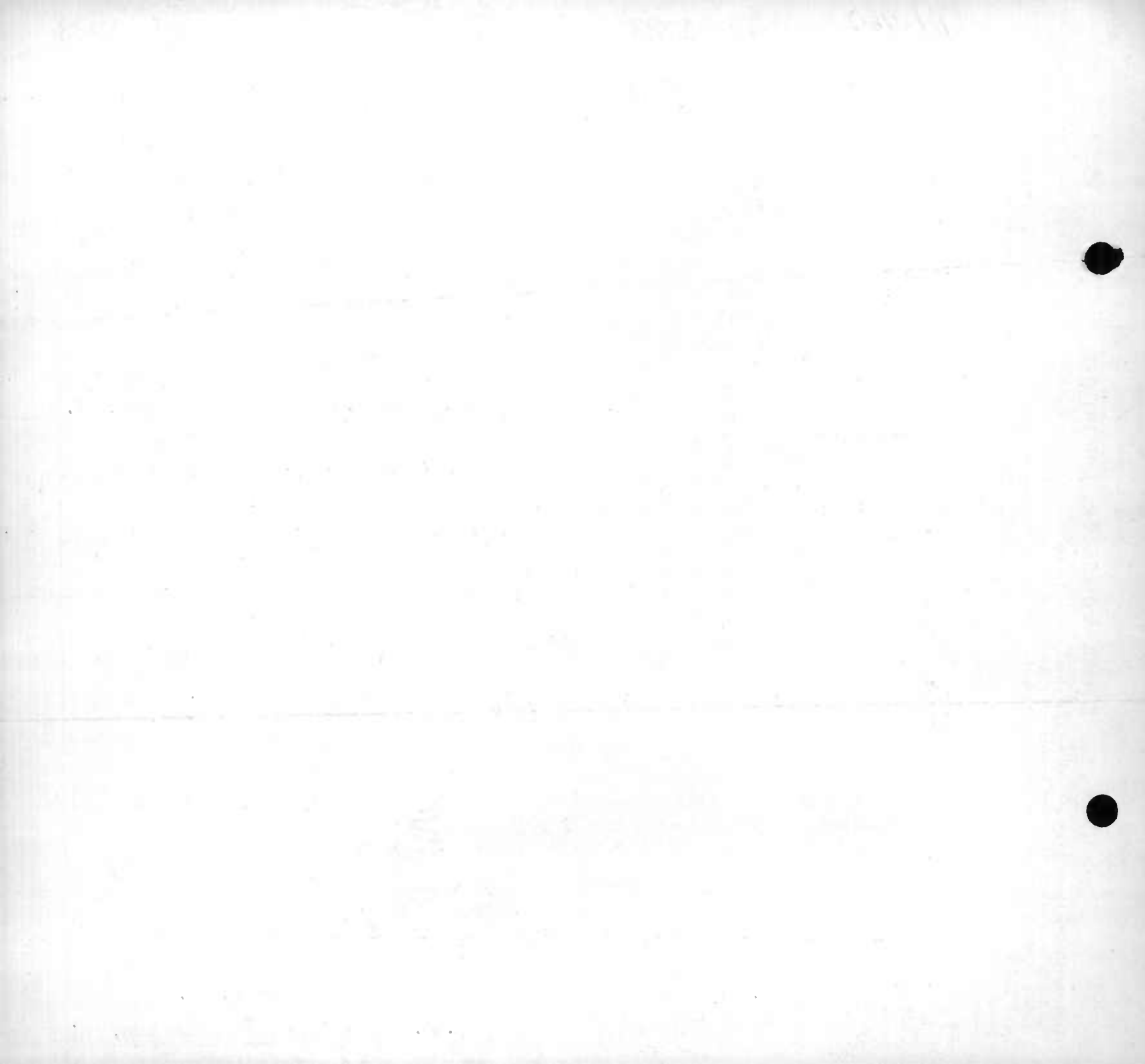
| | | | | | | | |
|--|-----------|---|--------------------------|--|---|--|----------------------------------|
| T-5/2 70 1722 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 70 1722 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) Eugene Xavier Thompson | | | |
| 2. DATE AND HOUR OF DEATH
Feb. 8, 1970 9:30 PM M. | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
US Public Health Service Hospital
3100 Wyman Parkway | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY A. A. C. 52-00 | | C. CITY OR TOWN Deale | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
Box 450A Rt. 1 | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/31/07 | 9. AGE (In years last birthday) 62 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Bernard Thompson | | | | 14. MOTHER'S MAIDEN NAME Isabel Roberck | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 240-07-2857 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) IMMEDIATE CAUSE
Due to, or as a consequence of: Acute myelocytic leukemia | | months | |
| 19. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I)/(this hospital) attended the deceased from Oct. 8 19 69 to Feb. 8 19 70, that (I)/(we) last saw the deceased alive on Feb. 8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)/(We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
P. Philpott MD | | | | 23B. DATE SIGNED
2/9/70 | | 23C. PHYSICIAN'S NAME (Type) Peter J. Philpott, Surgeon (R) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/12/70 | | 24C. NAME OF CEMETERY OR CREMATORY Woodfield's Cemetery | | 24D. LOCATION (City, town, or county) Galesville A.A. Md. | |
| 25A. DATE REC'D. BY HEALTH DEPT. FEB 13 1970 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR | | ADDRESS Harold's Funeral Home, Galesville | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| M-460 | | | | 70 1723 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1723 | |
|--|--|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) <i>Miller, George J.</i> | | | | 2. DATE AND HOUR OF DEATH
<i>Feb. 11, 1970</i> <i>4:00 P. M.</i> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Bolton Co.</i> <i>53-00</i> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>90 Bolton Hill Nursing & Convalescent Center</i> | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<i>Reisterstown</i> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<i>M</i> | | 6. RACE
<i>W</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>9-29-86</i> | | 9. AGE (In years lost birthday) <i># 83</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired Farmer</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>George Miller</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Annie Ealy</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | 16. SOCIAL SECURITY NO.
<i>12-01-9733</i> | | 17. INFORMANT ADDRESS
<i>Mrs. Helen L. Naylor Reisterstown, Md.</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>412.3 I</i> | | | | CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>anticoagulant treatment</i> | | | | <i>yes</i> | |
| | | | | (B) <i>anticoagulant treatment</i> | | | | <i>yes</i> | |
| | | | | (C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>6/18</i> <i>1967</i> to <i>2/11</i> <i>1970</i> , that (I) (we) lost saw the deceased alive on <i>2/11</i> <i>1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Alan H. MACHAT</i> | | | | 23B. DATE SIGNED
<i>2/11/70</i> | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Alan H. MACHAT</i> | | 23D. ADDRESS
<i>2 E Real St Balt, Md</i> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>Feb. 14, 70</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Greenmount Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Greenmount, Md.</i> | | | |
| 25A. DATE REC'D BY-HEALTH DEPT.
<i>FEB 13 1970</i> | | 25B. NAME OF REGISTRAR
<i>John E. Eline, Jr.</i> | | 25C. FUNERAL DIRECTOR
<i>J. F. Eline & Sons</i> | | ADDRESS
<i>Reisterstown, Md.</i> | | | |



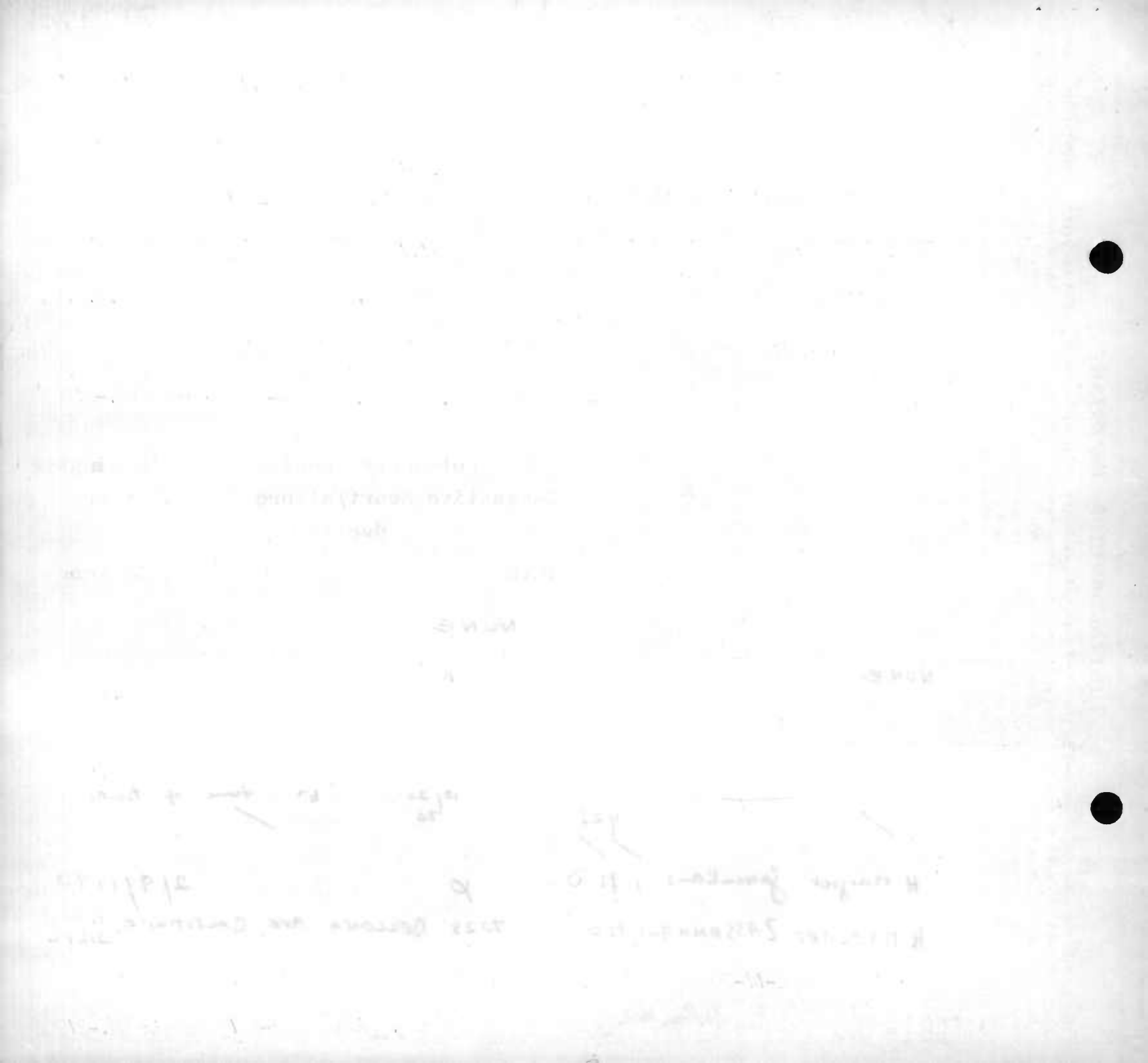
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 70 1724 |
|---|-------------------------|---|--|---|---|
| M-620 70 1724 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Josephina Marrocco</i> | | | 2. DATE AND HOUR OF DEATH
<i>February 7, 1970</i> <i>6:30 P.</i> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>44 Union Memorial Hospital</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>2631</i> | | |
| | | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<i>5937 Kavan Avenue- 21206</i> | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>May 21, 1890</i> | 9. AGE (In years lost birthday)
<i>79</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Home M ker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>New York, New York</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 13. FATHER'S NAME
<i>John Guariglia</i> | | |
| 14. MOTHER'S MAIDEN NAME
<i>Philomena Martucci</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | |
| 16. SOCIAL SECURITY NO.
<i>-</i> | | | 17. INFORMANT
<i>Mrs. Rose M. Taylor-5937 Kavan Ave.-21206</i> | | |
| 18. <i>412.4 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

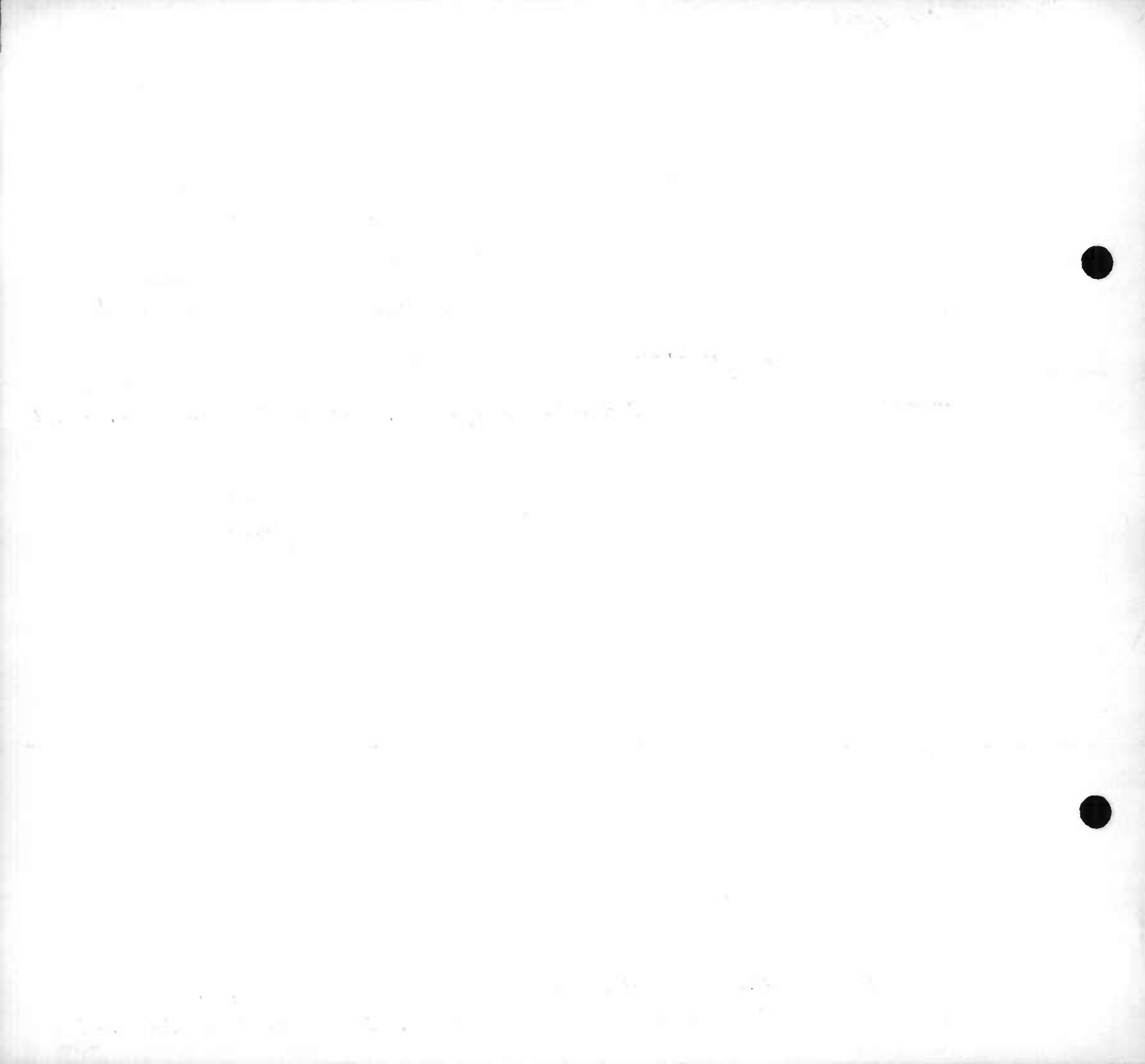
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<i>Pulmonary Embolus</i>
DUE TO, OR AS A CONSEQUENCE OF:
<i>Congestive Heartfailure</i>
(B) <i>due to</i>
DUE TO, OR AS A CONSEQUENCE OF:
<i>ACVD</i>
(C) <i>15 years</i> | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 minutes</i> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<i>NONE</i> | | | | | |
| 19A. DATE OF OPERATION
<i>NONE</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/20</i> 19 <i>67</i> to <i>time of death</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>1/23</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>H. Margret Zassenhaus, M.D.</i> | | | | 23B. DATE SIGNED
<i>2/9/1970</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>H. MARGRET ZASSENHAUS, M.D.</i> | | | | 23D. ADDRESS
<i>7028 BELLONA AVE, BALTIMORE, MARYLAND 21212</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2-11-70</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Holy Redeemer Cemetery</i> | |
| 24D. LOCATION
<i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 13 1970</i> | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. J. [illegible]</i> | | 25C. FUNERAL DIRECTOR
<i>John C. Miller Inc-6415 Belair Rd.-21206</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1725 | |
|--|-------------|--|--|--|--|
| BIRTH NO. 11-468 | | 70 1725 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) CORA A. MULLER | | | 2. DATE AND HOUR OF DEATH
2-9-70 9:45 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
48th. GENERAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE CITY 2735
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3017 ORLANDO AVENUE | | |
| 5. SEX F | 6. RACE CAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/6/91 | 9. AGE (In years lost birthday) 78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND U.S.A. | |
| 13. FATHER'S NAME CLEMENT B. ENGEL | | | 14. MOTHER'S MAIDEN NAME AMELIA WICKE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. 213-01-4781 | | 17. INFORMANT ADDRESS Calvin F. Muller - 3017 Orlando Ave. - 21214 | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/24 1970 to 2/9 1970 that (I) (we) lost saw the deceased alive on 2/4 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Enrique A. MD | | | 23B. DATE SIGNED 2/9/70 | | 23C. PHYSICIAN'S NAME (Type) ENRIQUE, A. MD |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-13-70 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 13 1970 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206 | |



FUNERAL DIRECTOR: IMPORTANT

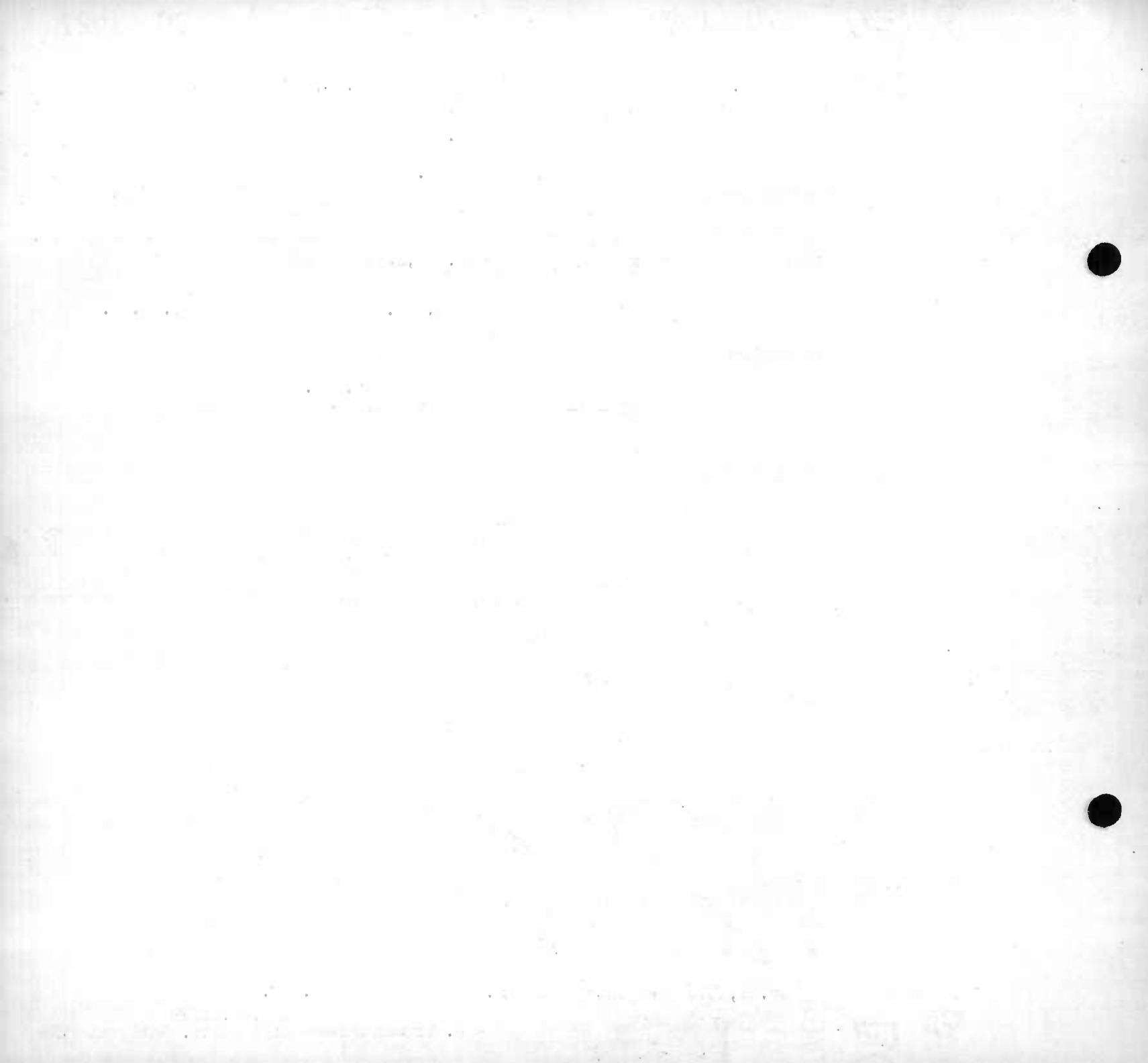
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|---------------------|---|------------------------------------|--|---|
| M-300 70 1726 | | 70 1726 | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) CAROLINE CARRE | | 2. DATE AND HOUR OF DEATH
2-10-1970 1:42 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
BON SECOURS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE BALTO. MD.
B. COUNTY BALTO.
C. CITY OR TOWN BALTO. MD.
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 3517 Sussex Rd. Balto. Md. 21207 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/11/92 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
ROBERT HORNEY | | 14. MOTHER'S MAIDEN NAME
HINDLE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-50-9258 | | 17. INFORMANT
Mrs. Rita Howell ADDRESS 3517 Sussex Rd. Balto. 7 | |
| 18. 4/12/71
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ARTERIO CARDIOVASCULAR DUE TO, OR AS A CONSEQUENCE OF: HEART DISEASE | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MOUTH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 - | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
- | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
- | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
- | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/13 19 70 to 2/10 19 70 that (I) (we) last saw the deceased alive on 2/10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Orathai Thirawat M.D. | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type)
ORATHAI THIRAWAT | |
| 23D. ADDRESS
BON SECOURS HOSPITAL BALTO. MD 23. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/12/70 | | 24C. NAME OF CEMETERY OR CREMATORY
New Cathedral | |
| 24D. LOCATION (City, town, or county) (State)
4300 Frederick Road. Md. | | | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Loring Byers | | 25C. FUNERAL DIRECTOR
Funeral Dir. 8728 Liberty Randallstown., Md. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

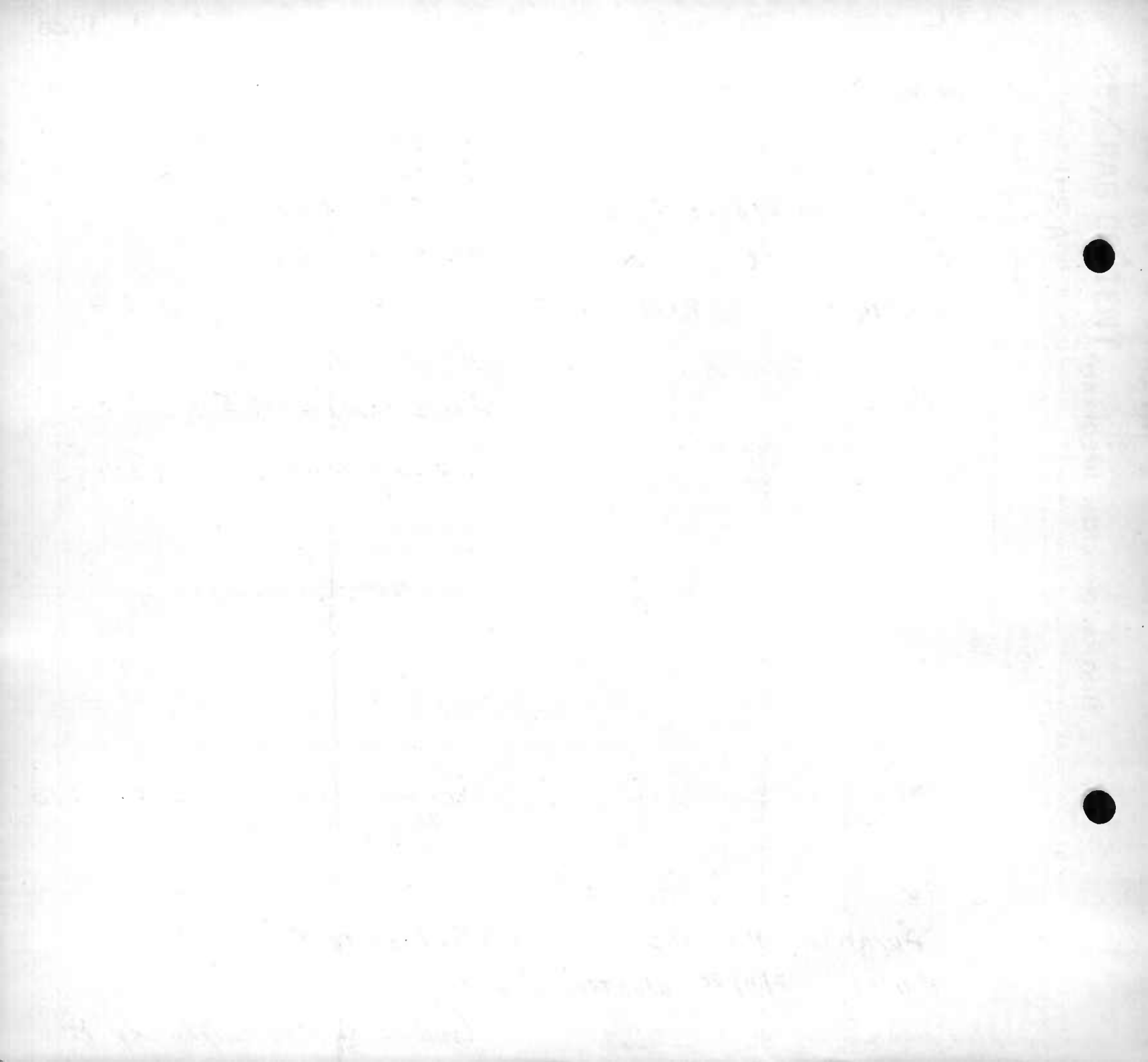
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|---------|--|---|---|--|
| N-140 70 1727 | | | | 70 1727 | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| Louise H. Napfel | | | | Feb. 8, 1970 2:15 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | |
| 00 4404 Adell Terrace | | | | Md. 2864 | |
| | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | | | Balto. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER | | | | | |
| 4404 Adell Terrace | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Oct. 17, 1879 | 90 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| House wife | | | Balto. Md. | | U. S. A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Adam Heimueller | | | Mary Sahl | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| | | | 219-32-0085 | | Balto. Md. 21229 Agnes Napfel 4404 Adell Terrace |
| 18. CAUSE OF DEATH | | | | | |
| I | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Coronary Thrombosis | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Cerebrovascular Disease Cerebral Embolism | | | | | |
| (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/24 1936 to 2/8 1970, that (I) (we) last saw the deceased alive on 2/4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Eliot W. Johnson MD | | | | 2/10/70 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | Feb. 11, 1970 | | New Cathedral Cem. | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| Balto. Md. | | FEB 13 1970 | | G. Truman Schwab | |
| 25A. FUNERAL DIRECTOR | | | | 25B. ADDRESS | |
| Balto. Md. 21229 | | | | 5151 Balto. National Pike | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|---------|---|------------------|---|---|
| H-653 70 1728 | | 70 1728 | | 70 1728 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Augusta R Harned | | 2/8/70 1:00 a.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Maryland | | 1401 | |
| House in the Pines | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 2525 W. Belvedere Ave | | E. STREET AND NUMBER
1615 Park Ave | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Female | White | | 7/25/78 | 91 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Waitress | | Restuarant | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| UNKNOWN | | UNKNOWN | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | Adale Hardy 2217 E. Lincoln Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Bronchopneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Cerebral arteriosclerosis | | unknown | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10-20 1970 to 2-8 1970, that (I) (we) last saw the deceased alive on 2-3 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Abraham B. Hurwitz | | | | 23B. DATE SIGNED
2-10-70 | |
| 23C. PHYSICIAN'S NAME (Type)
Abraham B. Hurwitz | | | | 23D. ADDRESS
7501 Liberty Rd Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
2/11/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Western Cemetery | |
| Burial | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Ruth E. Talbot | | 25C. FUNERAL DIRECTOR ADDRESS
Ambrose Dr 1328 Sulphur Sp. Rd. | |

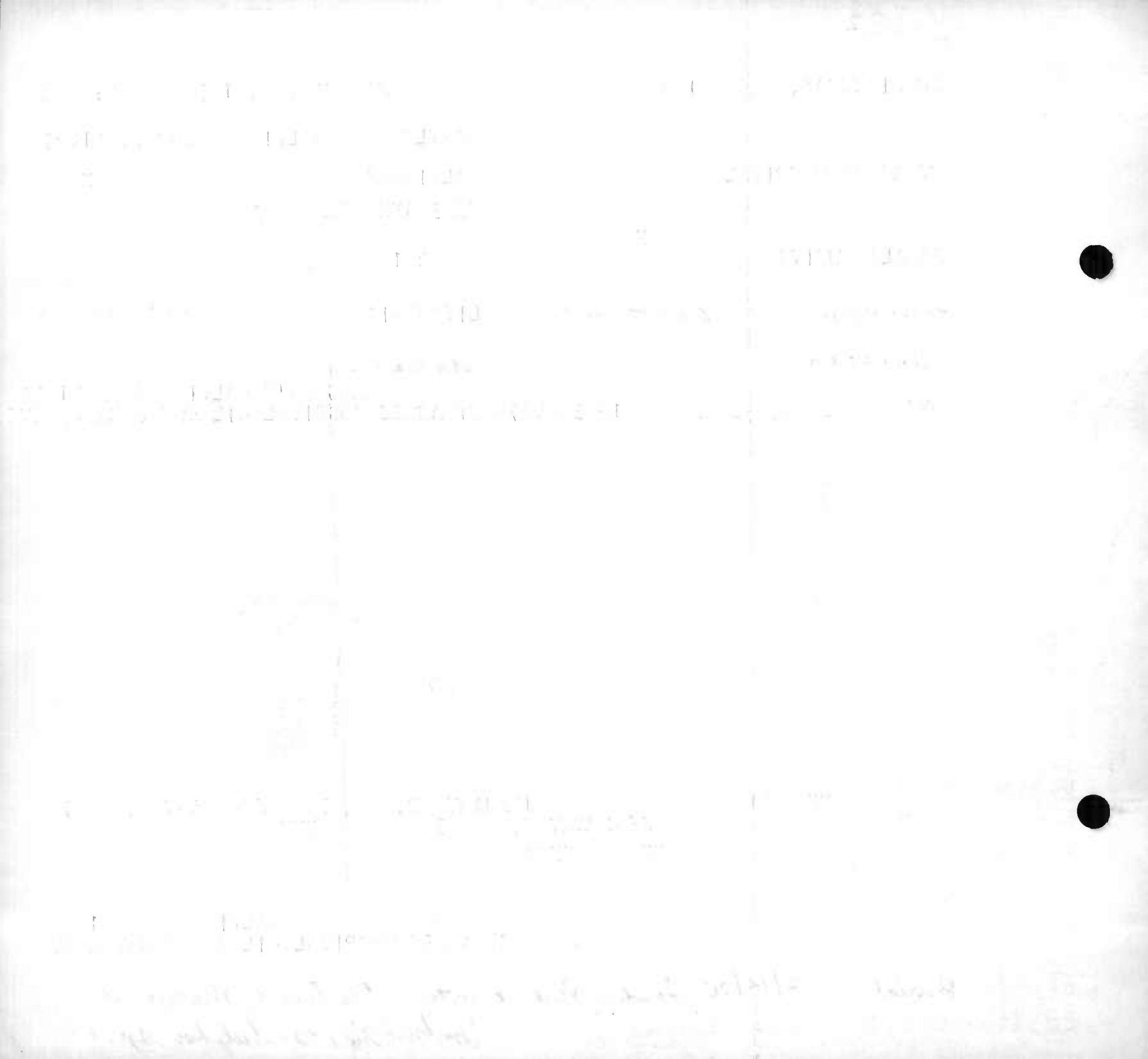


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|---|--|--|--|--|---|---|--|
| 70 1729 CERTIFICATE OF DEATH | | | | | REC. NO. 70 1729 | | | | |
| BIRTH NO. B-652 | | | | | 2. DATE AND HOUR OF DEATH
FEBRUARY 9, 1970 2:45 A.M. | | | | |
| 1. NAME OF DECEASED
(Type or Print) BURNIAUSKAS, MARGARITA | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST AGNES HOSPITAL | | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| | | | | | E. STREET AND NUMBER
5563 ASHBOURNE ROAD | | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
06 04 10 | 9. AGE (In years last birthday)
59 | 11. BIRTHPLACE (State or foreign country)
LITHUANIA | | 12. CITIZEN OF WHAT COUNTRY?
Lithuania | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 13. FATHER'S NAME
Unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service
NO | | | 16. SOCIAL SECURITY NO.
219 30 4874 | | 17. INFORMANT
Unknown | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
C. V. D.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
NO | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION
NO | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.)
1 Month 1 Day 1 Year 1 Hour | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from JANUARY 29, 1970 to FEBRUARY 9, 1970 that (X) (we) last saw the deceased alive on FEBRUARY 9, 1970 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>Stanley Anderson</i> | | | | | 23B. DATE SIGNED
2.9.70 | | | 23C. PHYSICIAN'S NAME (Type)
STANLEY ANDERSON | |
| 23D. ADDRESS
BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
2/12/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Landon Park Cemetery | | 24D. LOCATION
Baltimore, Maryland | | 24E. STONE | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Barber | | 25C. FUNERAL DIRECTOR
Anthony J. 1328 Sulphur Sp. Rd | | 25D. ADDRESS | | | |



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1730

BIRTH NO.

| | | | | | | | |
|---|--|------------------------|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
<p align="center">Elizabeth Johnson</p> | | | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
M. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<p>33 Hopkins Hospital</p> | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
2 7 70 9:07 a.m. | | | |
| 6. SEX
female | | | | 7. RACE
colored | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
7-4-1889 | | | | 10. AGE (In years lost birthday)
80 | | 11. BIRTHPLACE (State or foreign country)
St. Michael, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
Emory Davis | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 15. MOTHER'S MAIDEN NAME
Unknown | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS
Milton Pinkney 1022 McAleer Ct. 21202 | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
no | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
home | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1021 N. Chapel St. 808 | |
| 22D. TIME OF INJURY (APPROX.)
2 7 70 8:25 a.m. | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
housefire | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> M.D. Deputy Chief Medical Examiner
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 2/8/70 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-11-70 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS
1735 Harford Ave. 21213
Marshall W. Jones, Jr. | | | |

ACADEMY BOOK

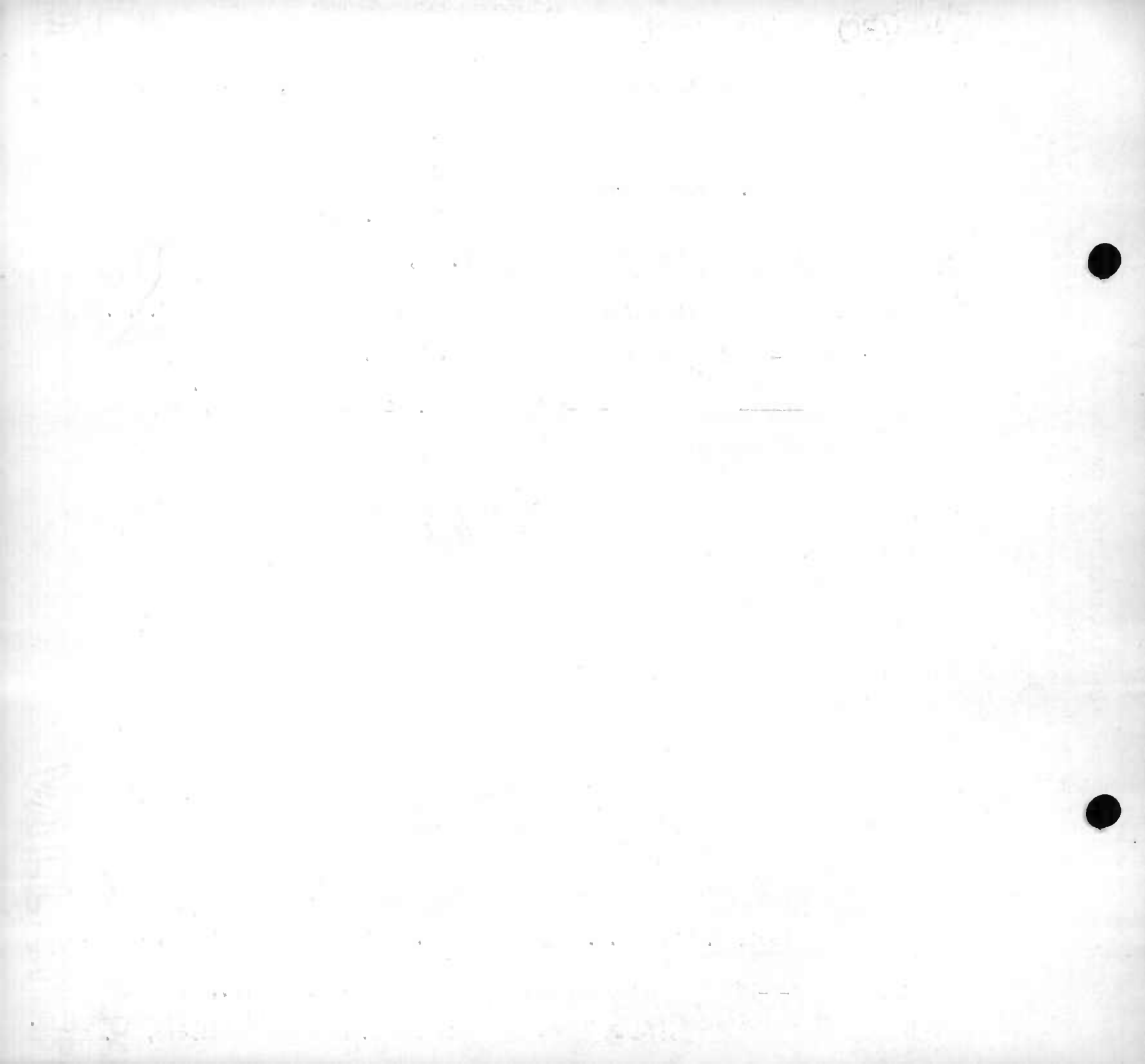
THE UNIVERSITY OF CHICAGO

Handwritten signature or initials

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 70 1731 |
|---|---------|--|---|--|---|
| G-430 70 1731 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Albert Nelson Gillett | | | February 7, 1970 5:30 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE | | |
| | | | B. COUNTY | | |
| 00 14 East Mt. Vernon Place | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER | | | 14 East Mt. Vernon Place | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Feb. 21, 1899 | 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Consultant | | Financial | | Pennsylvania | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Isaac - Gillett | | | Allie E. Seip | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT |
| No | | | 183-09-2447 | | 14 East Mt. Vernon Place |
| | | | Mary L. Gillett | | Baltimore, Maryland 21202 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | Coronary Infarction | | |
| ANTECEDENT CAUSES | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Emphysema & chronic bronchitis | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 13 1961 to Feb. 7 1970, that (I) (we) last saw the deceased alive on Feb. 7 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Louis E. Wice M.D. | | | | 2/9/70 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Louis E. Wice M.D. | | | | 920 St. Paul Street Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 2-9-70 | | Sater Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 13 1970 | | Robert E. Taylor | | William E. Johnson | |
| ADDRESS | | | | | |
| 8521 Loch Raven Blvd. Baltimore, Md. 21204 | | | | | |

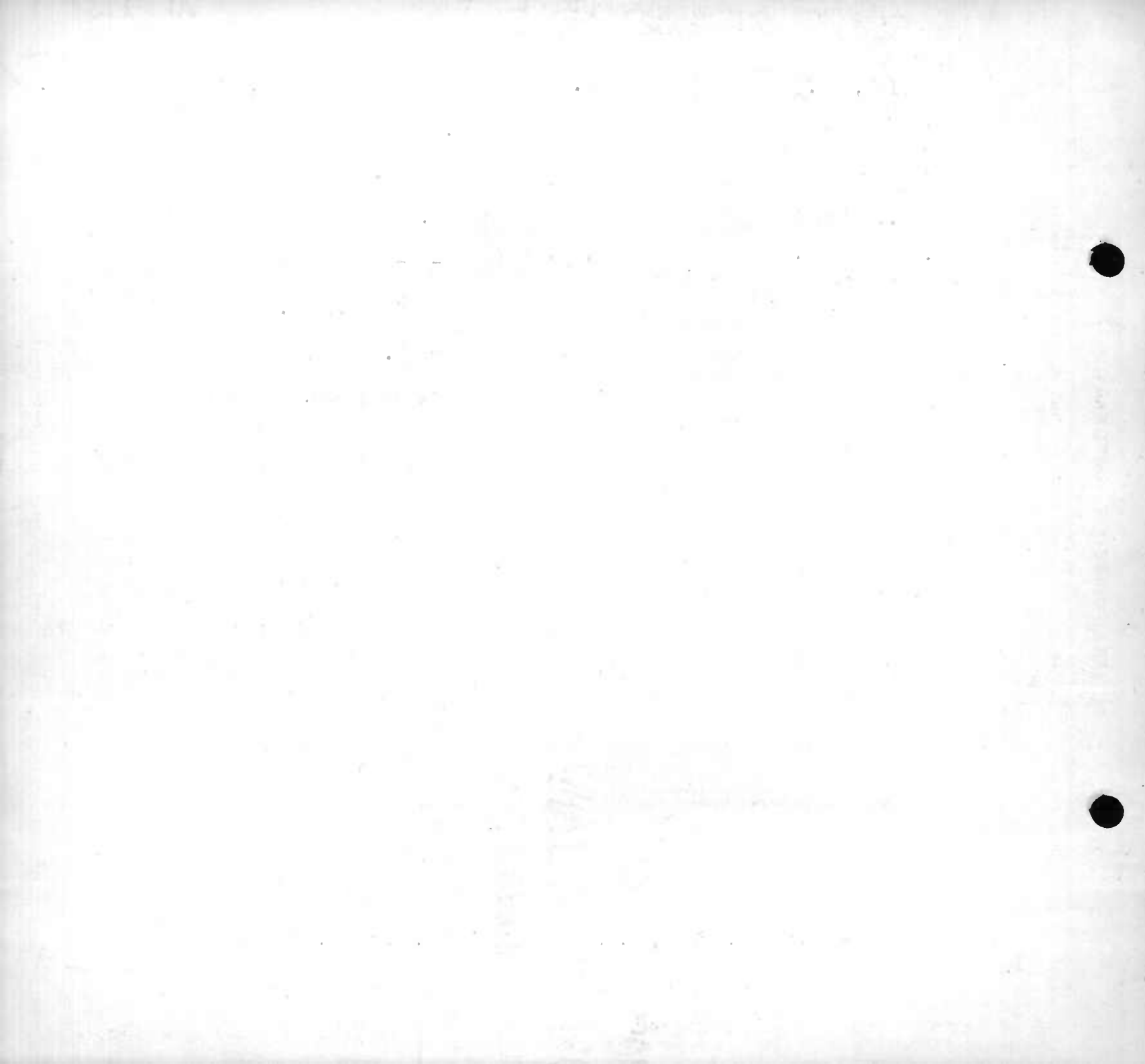


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> 5-530 70 1732 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 70 1732 </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Smith, Mr. Vernon Millard Jr. | | 2. DATE AND HOUR OF DEATH
February 7, 1970 7:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Keswick Home for Incurables of Balto., City | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY 1307 | | C. CITY OR TOWN
Balto. | |
| 5. SEX
M. | | 6. RACE
W. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
12-19-1909 | | 9. AGE (In years last birthday)
60 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Real Estate | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Balto., Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Millard Vernon Smith | | 14. MOTHER'S MAIDEN NAME
Anna V. Kendall | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Keswick records. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
4-12-4 I
Cerebral hemorrhage
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic CVD | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Cerebral hemorrhage
(B) DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerotic CVD
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
II
Rheumatoid Spindylitis (Gill's Disease) | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 19 1941 to 7 Feb 1970 , that (I) (we) last saw the deceased alive on 7 Feb 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Harold P. Biehl | | 23B. DATE SIGNED
8 Feb 70 | | 23C. PHYSICIAN'S NAME (Type)
Harold P. Biehl, M.D. | |
| 23D. ADDRESS
700 W. 40th St. 21211 | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
2/10/70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Cedar Hill Cem | | 24D. LOCATION (City, town, or county) (State)
A.A. County | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
J. Ticken & Sons | | 25D. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|------------------|---|----------------------------|---|--|
| U-453 | | 70 1733 | | 70 1733 | |
| 1. NAME OF DECEASED
(Type or Print) | | ELIZABETH WHAYLAND | | 2. DATE AND HOUR OF DEATH
2-6-70 9:00 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY
MARYLAND | | 1202 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
33 THE JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
348 E. UNIVERSITY PARKWAY | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-3-93 | 9. AGE (in years last birthday)
76 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
- - - | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
JACOB WEBSTER | | 14. MOTHER'S MAIDEN NAME
LAURA WINDSOR | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
217-16-5977 | | 17. INFORMANT (Son) ADDRESS
5509 Greenleaf Road
Mr. J. Wilson Whayland, Baltimore, Maryland | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Renal failure
(B) Papillary Carcinoma of Bladder
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
12/23/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
13x Bladder- | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month Day Year) (Hour)
APPROX. | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/16/69 to 2/6/70 that (I) (we) last saw the deceased alive on 2/6/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
W. B. Waddill | | 23B. PHYSICIAN'S NAME (Type)
W. B. WADDILL | | 23C. DATE SIGNED
2/6/70 | |
| 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | 23E. FUNERAL DIRECTOR
HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 23F. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/10/70 | | 24C. NAME of CEMETERY or CREMATORY
Hebron Cemetery | |
| 24D. LOCATION
Hebron, Wicomico, Maryland | | 24E. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 24F. NAME OF REGISTRAR
Robert E. Taylor | |

Y. A. 1. A. 1. A. 1. A.

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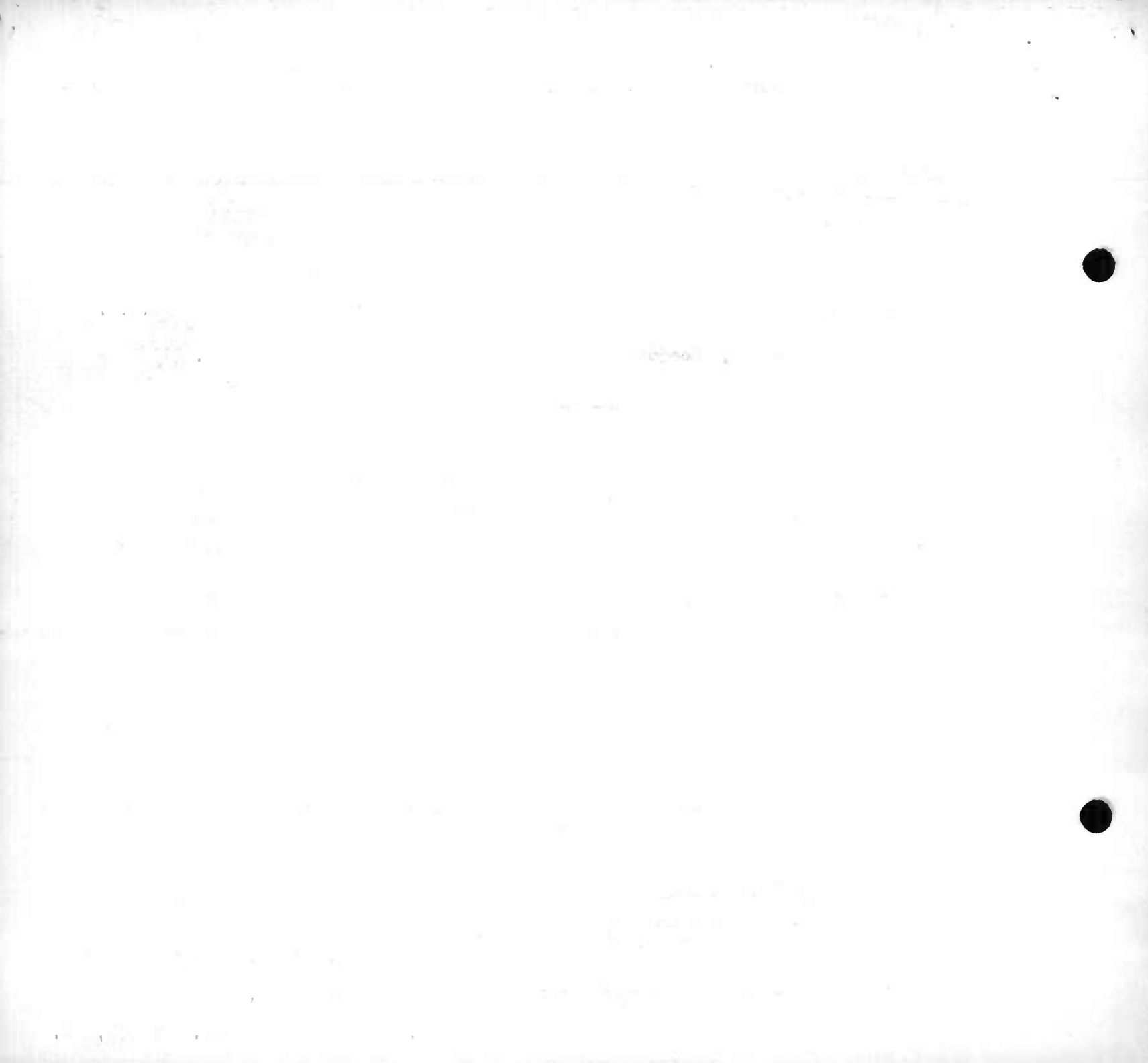
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Handwritten text, possibly a signature or name.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 36-75-35 d | | F-625 70 1734 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1734 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) Pearl Farson (Kemzura) | | | |
| 2. DATE AND HOUR OF DEATH
February 5, 1970 4:45 A. | | | | M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 2765 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female | | | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
10-28-19 | | | | 9. AGE (in years last birthday)
50 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
Edward F. Roedder | | | |
| 14. MOTHER'S MAIDEN NAME
Bessie F. Blimline | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
218-22-5719 | | | | 17. INFORMANT 4940 Eastern Avenue
Baltimore, Maryland 21224
BCH: Records | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Thrombocytopenia + Hemorrhage
HEMORRHAGING - ? brain
CHRONIC ALCOHOLISM POSTNOROTIC
PARANOSIS, FOLIC ACID DEFICIENCY
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
? DAYS
YEARS | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-14 19 70 to 2-5 19 70
that (I) (we) last saw the deceased alive on 2-5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Arnold I Levinson | | | | 23B. DATE SIGNED
2-5-70 | | 23C. PHYSICIAN'S NAME (Type)
ARNOLD I LEVINSON | |
| 23D. ADDRESS
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland | | 23E. DEGREE
DEGREE | | 23F. ADDRESS
John J. Duda
7922 Wise Ave. Dundalk, Md.
21222 | | 23G. DEGREE
DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-14-70 | | 24C. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
FEB 13 1970 | | 25B. DATE OF INTERMENT
2-14-70 | | 25C. FUNERAL DIRECTOR
John J. Duda | | 25D. ADDRESS
7922 Wise Ave. Dundalk, Md.
21222 | |



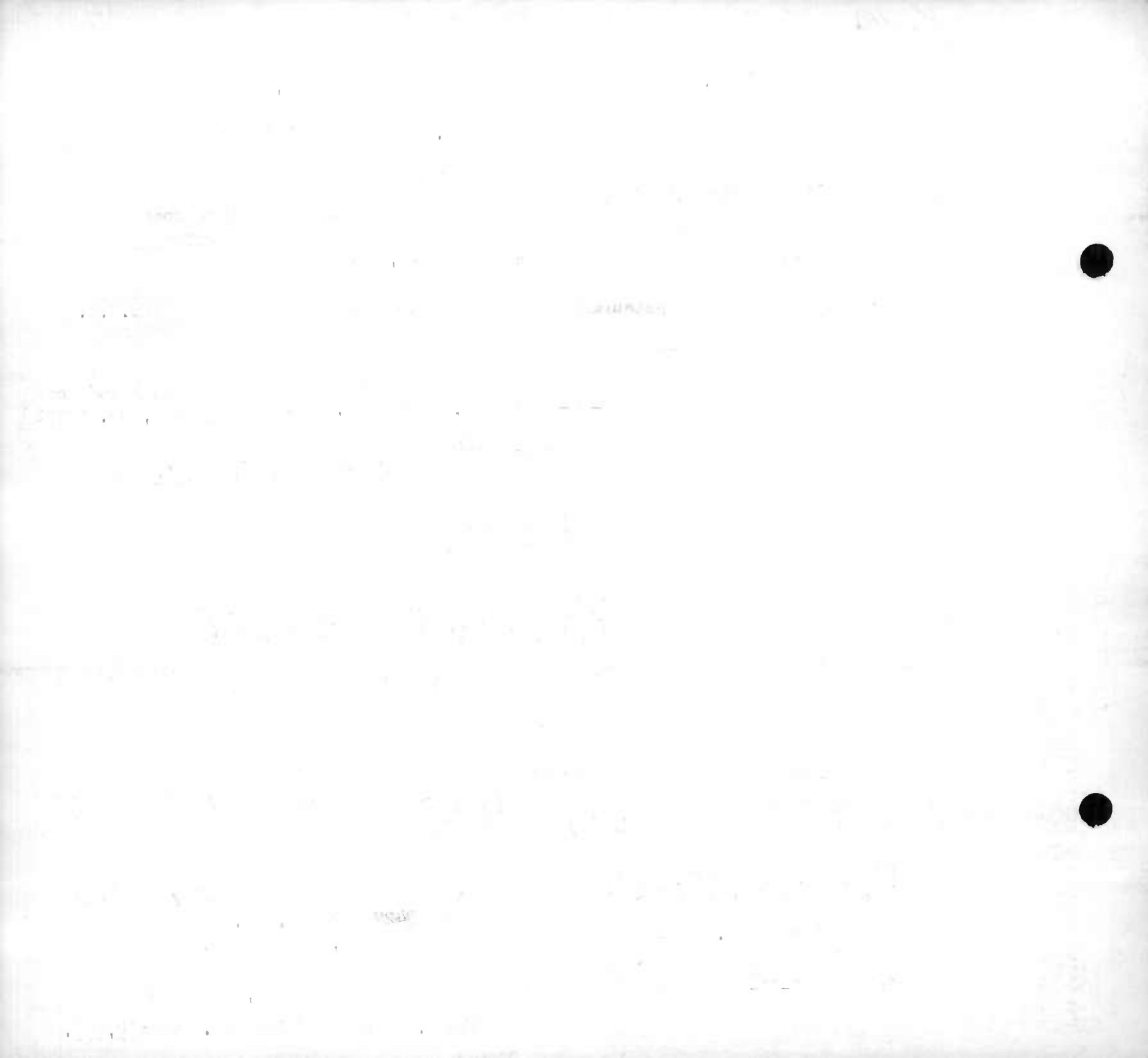
FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 70 1735 | |
|---|-------------------------|---|--|---|--|
| BIRTH NO. K-410 70 1735 | | 1. NAME OF DECEASED
(Type or Print) MAMIE B. KOLB | | 2. DATE AND HOUR OF DEATH
February 9, 1970 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
31 Baltimore City Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY Baltimore 5300 | | | |
| | | C. CITY OR TOWN
Dundalk | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER
7469 Berkshire Road | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
August 25, 1908 | |
| | | | | 9. AGE (In years last birthday) 61 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress | | 10B. KIND OF BUSINESS OR INDUSTRY
Restaurant | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
? Thomas | | 14. MOTHER'S MAIDEN NAME
? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-03-4258 | | 17. INFORMANT (Daughter)
Mrs. Christa C. Wheeler | |
| | | | | ADDRESS
7821 Lockwood Road Dundalk, Md. 21222 | |
| 18. 410.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Acute Coronary Occlusion | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
HCVD | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO OR AS A CONSEQUENCE OF:

(C) Myocarditis Acute | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/10 19 70 to 2/7 19 70 that (I) (we) last saw the deceased alive on 2/7 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Theodore C. Patterson | | DEGREE
— | | 23B. DATE SIGNED
2/10/70 | |
| 23C. PHYSICIAN'S NAME (Type)
Theodore C. Patterson | | 23D. ADDRESS
3427 Dundalk, Ave. Dundalk, Maryland 21222 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-12-70 | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
John J. Duda | |
| | | | | ADDRESS
7922 Wise Ave. Dundalk, Md. 21222 | |



1

T-462 70 1736 BALTIMORE CITY HEALTH DEPARTMENT X

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1736

BIRTH NO.

| | | | | | | | |
|--|-------------------------|---|--|---|------|---|------|
| 1. NAME OF DECEASED
(Type or Print) BARBARA TAYLORSON | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month | Day | Year | Hour |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
31 City Hospital | | 3. DATE PRONOUNCED DEAD
Month | | Day | Year | Hour | M. |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 2 | | 9 | 70 | 3:05 A. | M. |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore | | C. CITY OR TOWN
Dundalk | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 6. SEX
Female | 7. RACE
White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER
1319 Old North Point Road | | | |
| 9. DATE OF BIRTH
12-27-47 | | 10. AGE (In years last birthday)
22 | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Benjamin J. Taylorson, Sr. | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Librarian | | 14B. KIND OF BUSINESS OR INDUSTRY
Community College | | 15. MOTHER'S MAIDEN NAME
Loretta V. Gover | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO.
215-48-1105 | | 18. INFORMANT (Father) 1319 Old N. Pt. Rd. Benjamin J. Taylorson, Sr. Dundalk, Md. 21222 | | | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (A) IMMEDIATE CAUSE
Salicylate intoxication
DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (B) _____
DUE TO, OR AS A CONSEQUENCE OF: | | (C) _____ | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
no | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
house | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
858 Jeannett Ave. 5300 | | | |
| 22D. TIME OF INJURY (APPROX.)
2-8-70 ? m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subject ingested overdose. | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | ACTUAL EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
2-9-70 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-12-70 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Lawn | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
John J. Duda | | 25C. FUNERAL DIRECTOR ADDRESS
7922 Wise Ave. Dundalk, Md. 21222 | | | |

VS 151-REV. 1/1/68

70-1736

70-1736

1940-1941

1940-1941

1940-1941

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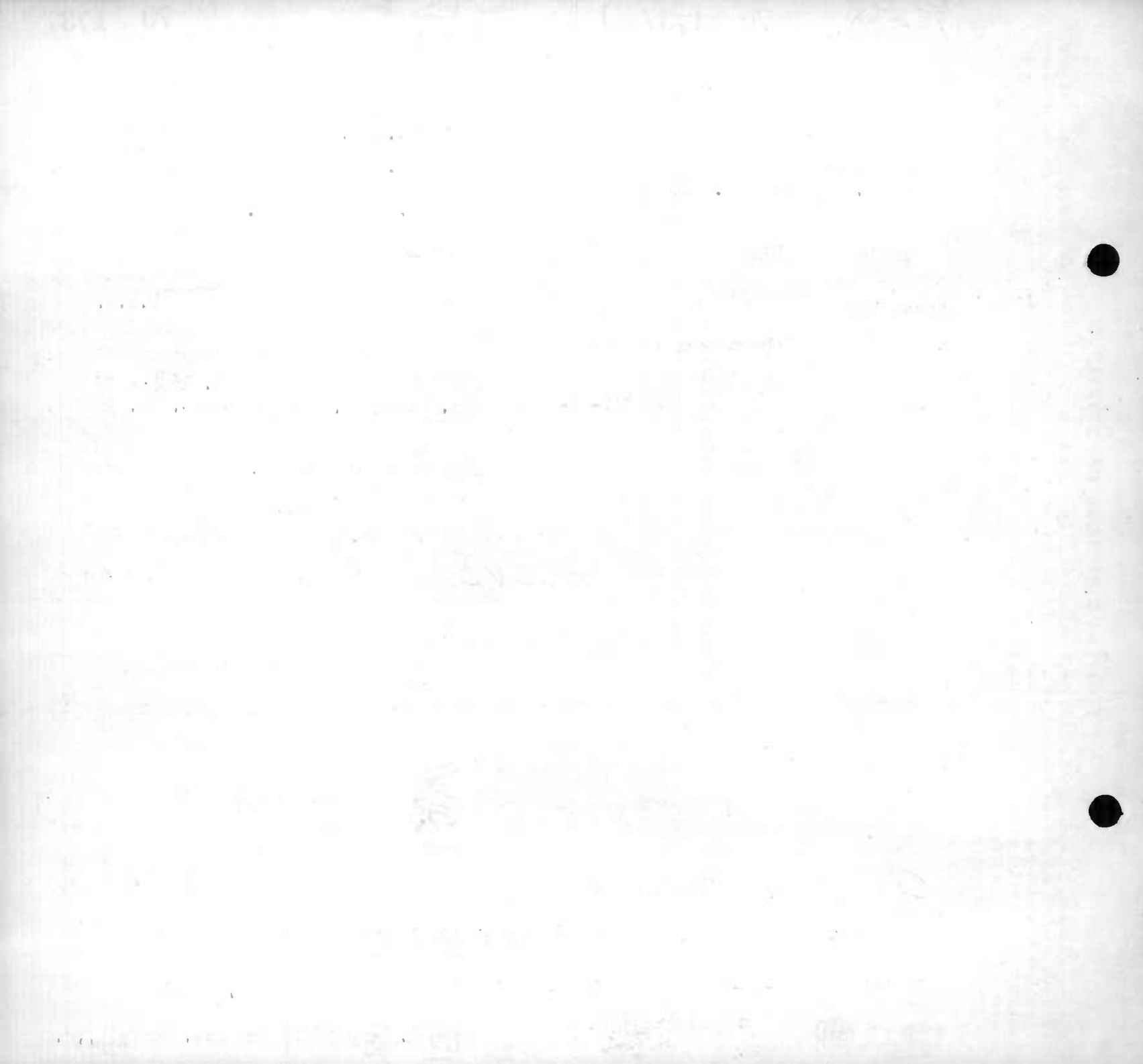
1940-1941

1940-1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

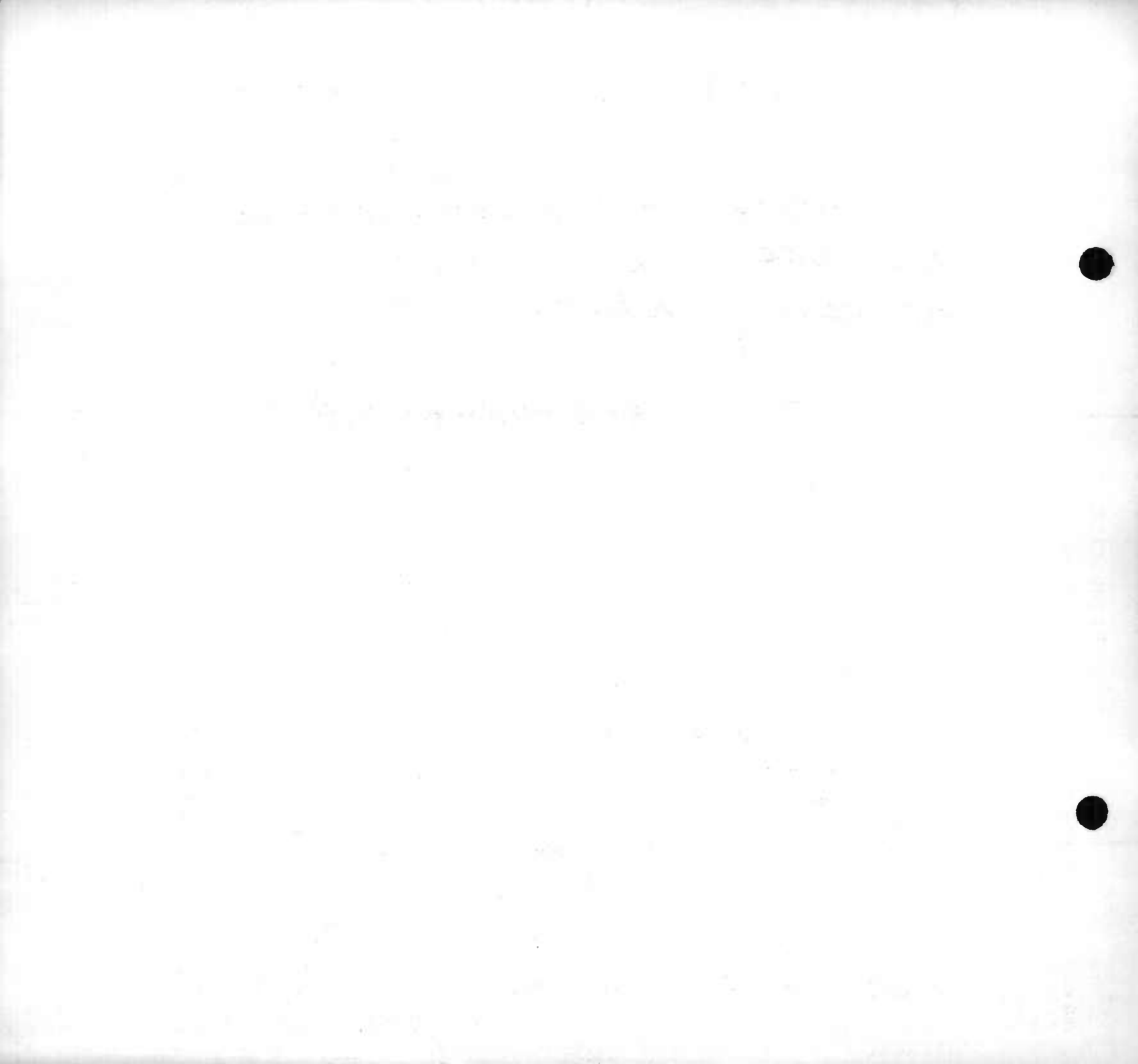
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|--|--|--|---|---|
| T-520 70 1737 | | | | 70 1737 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Edna Marie Thomas | | | 2. DATE AND HOUR OF DEATH
2-9-1970 11:05 pm M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 21223 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Bon Secours Hospital
2025 W. Fayette St. 21223 | | | C. CITY OR TOWN
Balto. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX Female 6. RACE white | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1-25-01 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday)
69 |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Robert Reck | | | 14. MOTHER'S MAIDEN NAME
Mary Steg | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
217-34-4389 | | 17. INFORMANT (Daughter) Rt. 16 Box 25 Mrs. George W. Phelps Balto. Md. 21220 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute Myocardial Infarction | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DAYS | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Acute Coronary Thrombosis | | | DUE TO, OR AS A CONSEQUENCE OF:
ASCVD | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-9-1970 to 2-9-1970 , that (I) (we) last saw the deceased alive on 2-9-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Agustin del Campo, MD | | | | 23B. DATE SIGNED
2-9-70 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
Box Secours Hosp. Balt. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-13-70 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
John J. Duda | | 25C. FUNERAL DIRECTOR ADDRESS
7922 Wise Ave. Dundalk, Md. 21222 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|---|--|
| S-530 70 1738 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1738 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) EVELYN V. SMITH | | 2. DATE AND HOUR OF DEATH
2-10-70 8⁰⁰ P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE md. B. COUNTY 1306 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
37 MERCY HOSPITAL | | C. CITY OR TOWN
Balto | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
Female | | 6. RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress (Retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Restaurant | | 8. DATE OF BIRTH
12-13-02 | |
| 13. FATHER'S NAME
? | | 14. MOTHER'S MAIDEN NAME
? | | 9. AGE (In years last birthday)
68 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
— | | 16. SOCIAL SECURITY NO.
220-07-1694 | | 17. INFORMANT
Charles R. Smith | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cardiac embolism | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Acute MI | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
min's | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ASCVD | | (B) DUE TO, OR AS A CONSEQUENCE OF:
ASCVD | | min's | |
| (C) years | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
No | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | |
| 22. I certify that the (this hospital) attended the deceased from 1/28 19 70 to 2/10 19 70 that the (we) last saw the deceased alive on 2/10 19 70 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Barbedo, M.D. | | 23B. DATE SIGNED
2/10/70 | | 23C. PHYSICIAN'S NAME (Type)
BARBEDO, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-13-70 | | 24C. NAME of CEMETERY or CREMATORY
Morland Mem. Park | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taber, M.D. | | 25C. FUNERAL DIRECTOR
Paul E. Geringer | |
| | | | | ADDRESS
365 Chestnut Ave. | |



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1739

BIRTH NO.

| | | | | | | | | | | | | | | | |
|---|--|-------------------------|--|---|--|--|--|--|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) <i>James EARL JONES</i> | | | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | | | Month | | Day | | Year | | Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
<i>31 Baltimore City Hospital</i> | | | | 3. DATE PRONOUNCED DEAD
Month <i>2</i> Day <i>9</i> Year <i>70</i> | | | | | | | | | | Hour <i>8:15 A.</i> | |
| | | | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> | | | | | | | | | | CITY OR TOWN <i>Owings Mill</i> | |
| 6. SEX
<i>Male</i> | | 7. RACE
<i>White</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH
<i>April 19, 1920</i> | | | | 10. AGE (In years last birthday)
<i>49</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Missouri</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 13. FATHER'S NAME
<i>James Jones</i> | | E. STREET AND NUMBER
<i>63 Tollgate Rd.</i> | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Welder for Crown Cork & Seal Co.</i> | | | | 14B. KIND OF BUSINESS OR INDUSTRY | | | | 15. MOTHER'S MAIDEN NAME
<i>Pearl Brumette</i> | | | | | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | | 17. SOCIAL SECURITY NO.
<i>405-12-9786</i> | | | | 18. INFORMANT
<i>Mrs. Ruth M. Jones Owings Mills, Md.</i> | | | | ADDRESS | | | |
| 19. CAUSE OF DEATH
<i>412.4 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | | | | | |
| 20A. DATE OF OPERATION
<i>2</i> | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 21. AUTOPSY? (Yes or No)
<i>yes</i> | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | | | | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? | | | | | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE <i>Russell S. Fisher</i> M.D.
EXAMINER'S NAME (Type) <i>Russell S. Fisher, M.D.</i>

CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>

DATE SIGNED <i>2-9-70</i> | | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | 24B. DATE
<i>Feb. 12, 70</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Lakeview Memorial</i> | | | | 24D. LOCATION (City, town, or county) (State)
<i>Sykesville, Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 13 1970</i> | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | | | 25C. FUNERAL DIRECTOR
<i>J. F. Eline & Sons</i> | | | | ADDRESS
<i>Reisterstown, Md.</i> | | | |

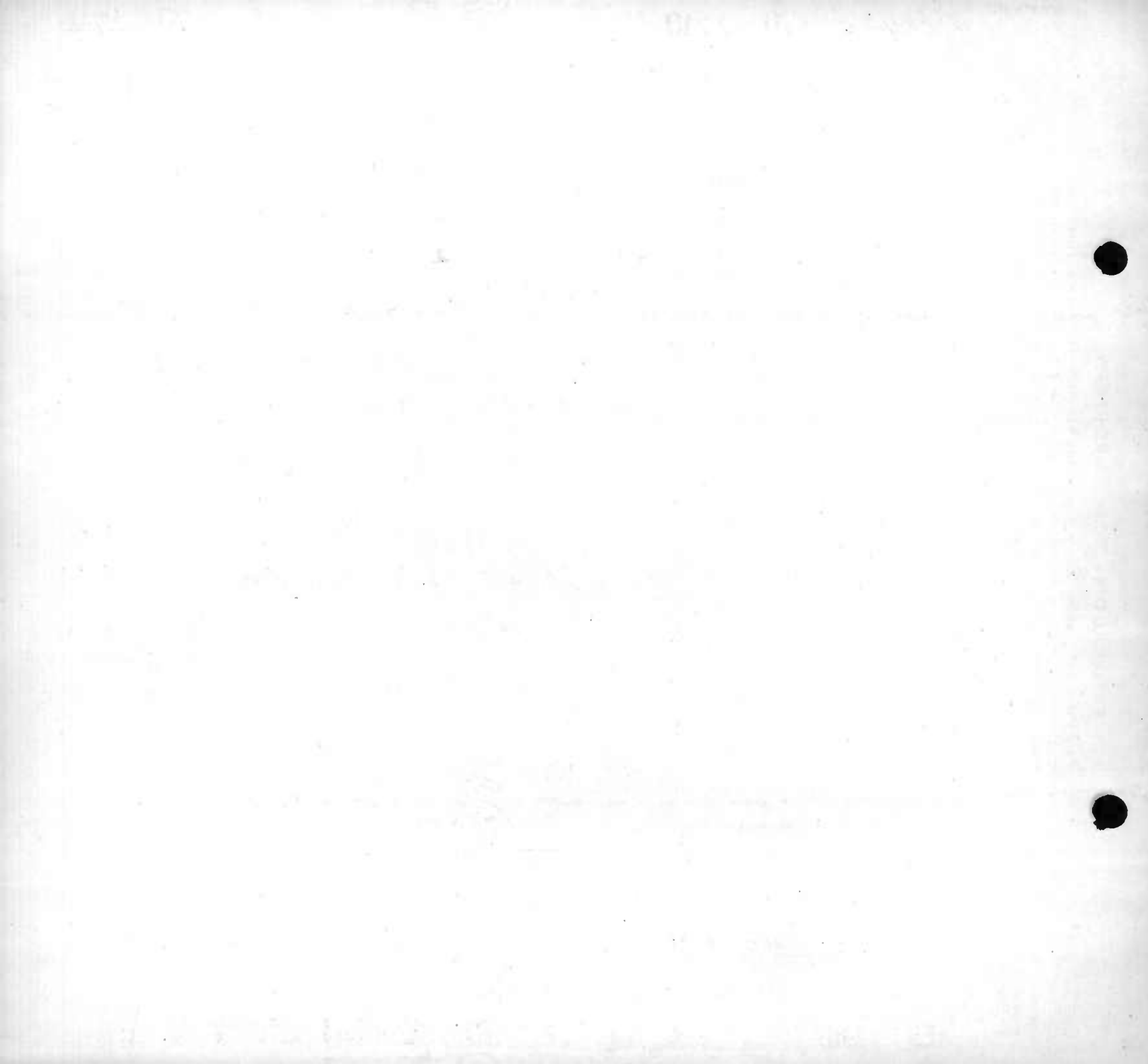
RECEIVED BY THE OFFICE OF THE ATTORNEY GENERAL

ACADEMIC & BOLD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|---|---|--|
| BIRTH NO. 17-420 | | Baltimore City Health Department | | REG. NO. 70 1740 | |
| 1. NAME OF DECEASED
(Type or Print) Arthur Milste | | | 2. DATE AND HOUR OF DEATH
Feb. 11, 1970 12:50 A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Jenkins Memorial Hosp | | | A. STATE Md B. COUNTY Baltimore | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 91 | | | E. STREET AND NUMBER 19 Maple St | | |
| 5. SEX M | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/2/1899 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) construction president of Co. | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Charles A. Milste | | | 14. MOTHER'S MAIDEN NAME Ida Bosse | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. 217-12-5330 | | |
| 17. INFORMANT Records Jenkins Mem Hosp | | | ADDRESS | | |
| 18. 519.2 I | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Vascular shock | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs | | |
| ANTECEDENT CAUSES | | | (B) Pneumonia | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | DUE TO, OR AS A CONSEQUENCE OF: 6 hrs | | |
| II | | | (C) Chronic Obstructive Pulmonary Disease | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | DUE TO, OR AS A CONSEQUENCE OF: 4 yrs | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED | | | 21F. HOW DID INJURY OCCUR? | | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/20 1969 to 2/11 1970 , that (I) (we) last saw the deceased alive on 2/11 1970 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Raymond Gladue | | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) J. Raymond Gladue | | | 23D. ADDRESS Jenkins Memorial Hospital | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | | 24B. DATE 2/14/70 | | |
| 24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 13 1970 | | | 25B. NAME OF REGISTRAR Robt E. Taylor | | |
| 25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc | | | ADDRESS 1050 York Road Baltimore, Md. 21204 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| P-160 70 1741 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1741 | |
|--|---------------------|---|--|---|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) PIEPER HENRY James | | 2. DATE AND HOUR OF DEATH
2-11-70 2:00 P. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY 2710 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL HOSP | | C. CITY OR TOWN
BALT. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
4337 YORK RD. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2-24-89 | 9. AGE (In years last birthday)
80 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DENTIST | | 10B. KIND OF BUSINESS OR INDUSTRY
DENTIST | | 11. BIRTHPLACE (State or foreign country)
NEW YORK | |
| 13. FATHER'S NAME
UNKNOWN | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | 12. CITIZEN OF WHAT COUNTRY
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes WWI | | 16. SOCIAL SECURITY NO.
08803-1306 | | 17. INFORMANT
C.A. Ruppberger - 306 W Chesapeake Ave Towson Md 21204 | |
| 16. 437.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
CEREBRAL ISCHEMIA
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ARTERIOSCLEROSIS | | CAUSE OF DEATH
CEREBRAL ISCHEMIA
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
ARTERIOSCLEROSIS
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2-13-1970 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-5-1970 to 2-11-1970 that (I) (we) last saw the deceased alive on 2-10-1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. Shaffer M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
2-11-70 | |
| 23C. PHYSICIAN'S NAME (Type)
J. SHAFFER, M.D. | | 23D. ADDRESS
THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2-13-1970 | | 24C. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Memorial | |
| 24D. LOCATION (City, town, or county) (State)
Cockeysville, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Naber, R.D. | |
| 25C. FUNERAL DIRECTOR
W. Cook & Brooks | | ADDRESS
Towson, Md 21204 | | | |

W3 - 3455 - 38W

08 PB-72-2

W3W W3W

W3W W3W

W3W W3W

W3W W3W

W3W W3W

W3W W3W

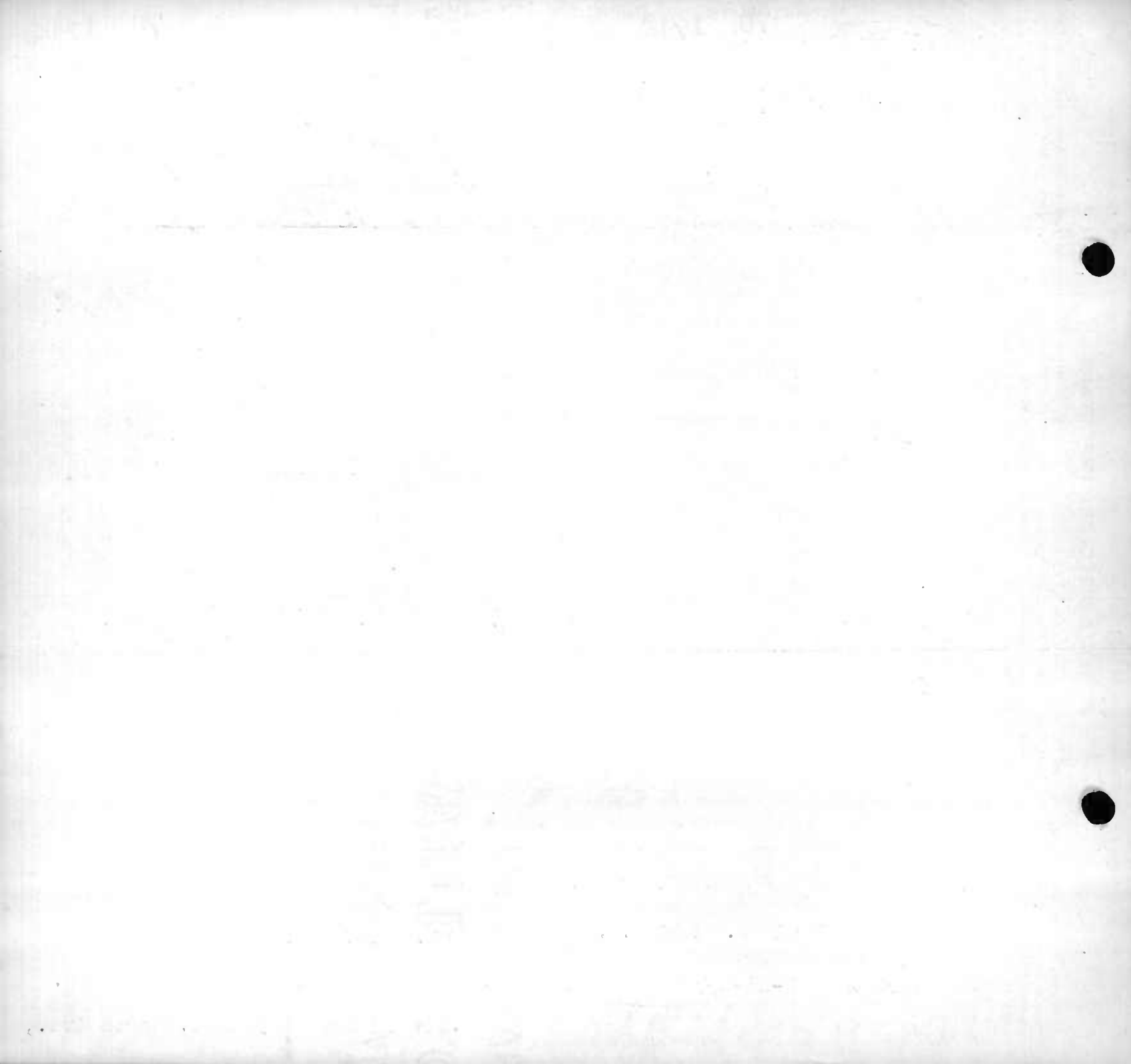
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| K-156 | | 70 1742 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1742 | |
|--|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) <i>Kue H. ner Mrs Edna Likens young</i> | | | | 2. DATE AND HOUR OF DEATH
<i>February 8-1970 8:55 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
<i>91 Reswick Home for Incurables</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>1307</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>91 Reswick Home for Incurables</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<i>Female</i> | | 6. RACE
<i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>May 10 1897</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Practical Nurse</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Nursing</i> | | 9. AGE (In years last birthday)
<i>72</i> | | 11. BIRTH PLACE (State or foreign country)
<i>Baltimore Maryland</i> | |
| 13. FATHER'S NAME
<i>John George Young</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Harriett Elizabeth Necholson</i> | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>217-36-3291</i> | | 17. INFORMANT
<i>Keswick records</i> | | | |
| 18. <i>495X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Bronchopneumonia</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 days</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<i>Gen. arteriosclerosis with residual hemiplegia</i> | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White AI <input type="checkbox"/> Nat White AI Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>JANUARY 1962</i> to <i>8 Feb 1970</i> , that (I) (we) last saw the deceased alive on <i>8 Feb 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Harold P. Biehl 40</i> | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>2 Feb 1970</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Harold P. Biehl M.D.</i> | | | | 23D. ADDRESS
<i>700 W. 40th Street</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2-11-1970</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Lorraine Park</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Woodlawn Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 13 1970</i> | | 25B. NAME OF REGISTRAR
<i>G. Howard Strong</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>3207 W. North Ave.,</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

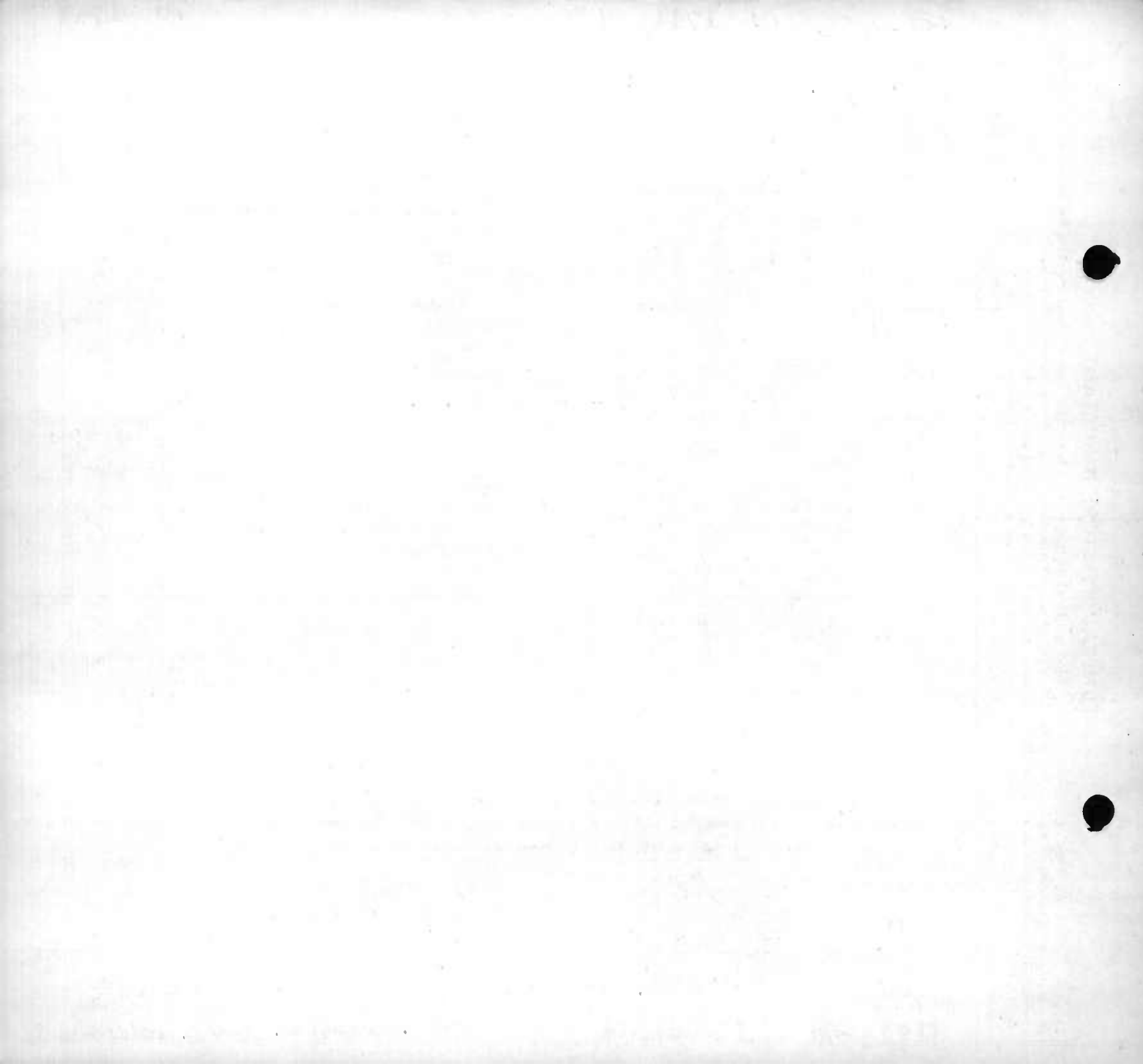
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|---------|--|---|--|---|
| E-152 70 1743 | | 70 1743 | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Thelma Evans | | 2-10-1970 2020 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE B. COUNTY | | |
| 00 4736 Dartford Ave. 21229 | | | Baltimore, Md. 2854 | | |
| | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Balto. Md | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 4736 Dartford Ave 21229 | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years) | If Under 1 Yr. Months Days |
| F | W | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11-18-1894 | 75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Robert Ford Bean | | | Rowena Foxwell | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 214-54-3329
577-05-3787 | | Mrs. Rowena Corrigan 4736 Dartford 21229 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| 430.9 I | | | Subarachnoid Hemorrhage | | |
| ANTECEDENT CAUSES | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II | | | Chr. Brain Syndrome | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | Medical Examiner's Office | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2:10 1970 to 2:10 1970, that (I) (we) last saw the deceased alive on 2:10 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| John F. Schaefer MD | | | 2/11/70 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| Dr. John F. Schaefer | | | 401 Random Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | | | New Cathedral | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Frederick Ave. Balto. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 13 1970 | | Robert E. Fisher | | Hubbard Funeral Home 4107 Wilkens Ave. | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| W-420 70 1744 | | | | BALTIMORE CITY HEALTH DEPT. | | 70 1744 | |
|---|---------------------|--|--|--|---|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print)
<i>LOUIS A. WALLACE</i> | | 2. DATE AND HOUR OF DEATH
<i>2/9/70 10³⁰ PM</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>2719</i> | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>PLEASANT MANOR Nursing Home</i>
<i>4615 PLEASANT PARK HILLS AVE</i>
<i>BALTIMORE 21215 MD.</i> | | | | C. CITY OR TOWN
<i>Balt.</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
<i>5718 Bland Avenue</i> | | | | | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>4/22/97</i> | 9. AGE (In years last birthday)
<i>72</i> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Messenger</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Brinks</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Massachusetts</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> |
| 13. FATHER'S NAME
<i>Louis Wallace</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Mary Ellen Young</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<i>215-05-0201</i> | | 17. INFORMANT ADDRESS
<i>Mrs. S. Kathryn Wallace 5718 Bland Ave</i> | |
| 18. <i>486X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 weeks</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<i>Parkinson's Disease</i> | | | | <i>10 YRS</i> | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>7/31/69</i> 19 <i>70</i> to <i>2/9</i> 19 <i>70</i> , that (2) (we) last saw the deceased alive on <i>2/9</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Leon S. Sheer, MD</i> | | | | 23B. DATE SIGNED
<i>2/9/70</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>LEON G. SHEER MD</i> | |
| 23D. ADDRESS
<i>6715 NANT HEIGHTS AVE</i> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2/12/70</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Mt. Zion Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Fountain Green, Maryland</i> | |
| 25A. DATE REG'D BY HEALTH DEPT.
<i>FEB 13 1970</i> | | 25B. NAME OF REGISTRAR
<i>John A. Moran, Inc.</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>3000 E. Baltimore St</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

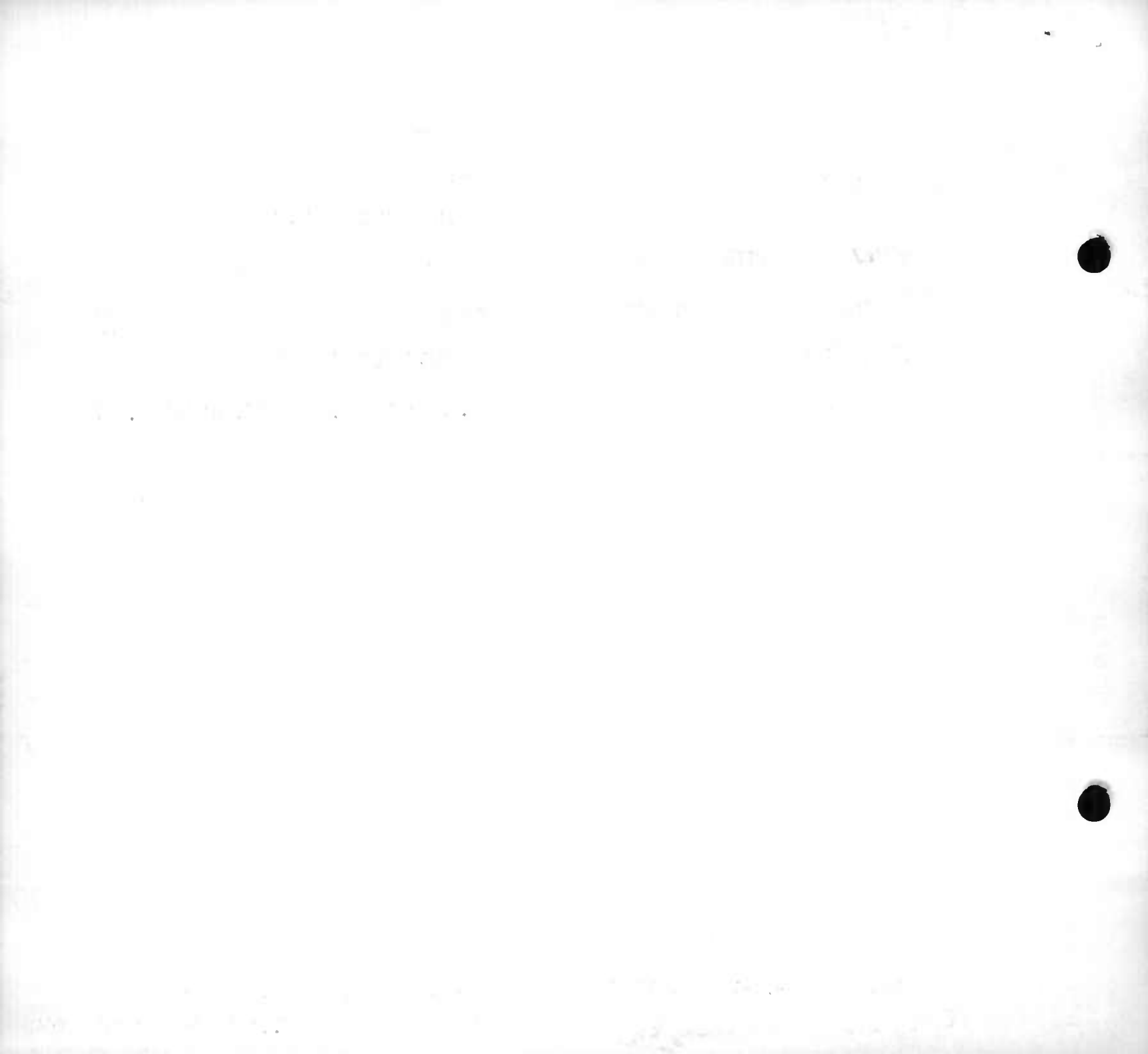
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | |
|---|---------------------|---|--|--|---|---|
| G-653 | | 70 1745 | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | 70 1745 |
| BIRTH NO. | | | 1. NAME OF DECEASED
(Type or Print) LEMUEL B. GRANDSTAFF | | | |
| 2. DATE AND HOUR OF DEATH
2-9-70 2:15 P.M. | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 2610 | | | FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
37 MERCY HOSPITAL | | | |
| C. CITY OR TOWN
Baltimore | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER
3221 Esther Place | | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8/23/'15 | | 9. AGE (In years last birthday)
54 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Factory Worker retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Jefferson County, W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA. |
| 13. FATHER'S NAME
Garland B. Grandstaff | | | 14. MOTHER'S MAIDEN NAME
Ella Ashby | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes WW 17 | | 16. SOCIAL SECURITY NO.
232-26-4566 | | 17. INFORMANT
Mrs. Hettie T. Grandstaff | | |
| | | | | ADDRESS
3221 Esther Pl | | |
| 18. 519.2 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Respiratory failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
COLD | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Respiratory failure
(B) DUE TO, OR AS A CONSEQUENCE OF:
COLD
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days
year
months | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Cor pulmonale | | | | | | |
| 19A. DATE OF OPERATION
1/26/70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Respiratory failure: Tracheostomy | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (this hospital) attended the deceased from 1/31 19 70 to 2/9 19 70 that (we) last saw the deceased alive on 2/9 19 70 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death. | | | | | | |
| 23A. SIGNATURE
Barredo, MD | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
2/9/70 | |
| 23C. PHYSICIAN'S NAME (Type)
BARBEDO, MD | | | 23D. ADDRESS
MERCY HOSP | | | |
| 24A. BURIAL CREMATION, REMOVAL, (Specify)
Burial | | 24B. DATE
2/11/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
John A. Moran, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS
3000 E. Baltimore St | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|---|---|--|--|---|-----------------------------|---|--|
| 70 1746 CERTIFICATE OF DEATH | | | | | X REG. NO. 70 1746 | | | | |
| BIRTH NO. <u>W-410</u> | | | | | 1. NAME OF DECEASED
(Type or Print) <u>GUSSIE WOLFF</u> | | | | |
| 2. DATE AND HOUR OF DEATH
<u>Feb. 10 1970</u> <u>5:00 AM</u> M. | | | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>SINAI HOSPITAL</u>
<u>42</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>Balto. Co.</u>
C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>4315 LABYRINTH ROAD</u> | | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7/14/1878</u> | 9. AGE (In years last birthday)
<u>91</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | | | 11. BIRTHPLACE (State or foreign country)
<u>RUSSIA</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | 13. FATHER'S NAME
<u>MARSHALL TURNER</u> | | | 14. MOTHER'S MAIDEN NAME
<u>MAYTA NECHEL ?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS
<u>MRS. ANNA RUBIN, 4315 LABYRINTH RD. #15</u> | | | |
| 18. <u>445.01</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>cardiorespiratory insufficiency</u>
<u>generalized atherosclerosis</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>infected stump after amputation of left leg (gangrene)</u> | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>II</u> | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>1/23/70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>stump of left leg (amputation)</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 19, 1970</u> to <u>Feb. 9, 1970</u> that (I) (we) last saw the deceased alive on <u>Feb. 9, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>JOAO C. ARAUJO, M.D.</u> | | | | | 23B. DATE SIGNED
<u>Feb. 10, 1970</u> | | | 23C. PHYSICIAN'S NAME (Type)
<u>JOAO C. ARAUJO, M.D.</u> | |
| 23D. ADDRESS
<u>SINAI HOSPITAL OF BALTIMORE</u> | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>2-11-70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>BETH YEHUDA ANSHE KURLAND</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTIMORE, MARYLAND</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 13 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>SOL LEVINSON & BROS.</u> | | 25D. ADDRESS
<u>6010 REISTERSTOWN ROAD</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. | |
|---|--|--|--|--|--|
| S-416 | | 70 1747 | | 70 1747 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Mr. Irvin G. Silverman | | Feb. 9, 1970 7:45 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
B. COUNTY | | | |
| Maryland General Hospital | | MARYLAND | | 27-19 | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 3701 WYLLIE AVENUE | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| MALE | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| MAINTENANCE | | GENERAL MOTORS | | 1-15-1921 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| JOSEPH SILVERMAN | | FANNIE GOLDSTEIN | | 49 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | 214-16-9616 | | MRS. SARA SILVERMAN, 5731 SIMMONDS AVE. #15 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | ASPIRATION of GASTRIC CONTENTS | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| that (I) (we) last saw the deceased alive on | | Shao-Huang Chiu | | Feb. 9, 1970 | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| | | SHAO HUANG | | SINAI | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 2-11-70 | | AITZ CHAIM | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 13 1970 | | Robert E. Fisher | | SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

Address is 5731 Simmonds ave.
Called hospital for information.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1748</u> |
|---|---|---|--|---|
| H-620 <u>70 1748</u> | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>JOHN HARRIS</u> | | 2. DATE AND HOUR OF DEATH
<u>11 February 1970</u> <u>1</u> <u>2⁰⁰</u> <u>P</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>1803</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>38 University of Maryland Hospital</u> | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
<u>804 Hollins Street</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10/4/75</u> | 9. AGE (In years last birthday)
<u>94</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | 11. BIRTHPLACE (State or foreign country)
<u>?</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Alfred Harris</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Queen</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) | | 16. SOCIAL SECURITY NO.
<u>219-05-9176</u> | 17. INFORMANT
<u>Chas</u> | ADDRESS |
| 18. <u>577.0 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>Hypovolemic Shock</u>
DUE TO, OR AS A CONSEQUENCE OF:

(B) <u>Possibly acute pancreatitis</u>
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 hrs.</u>

<u>48 hrs. ±</u>

<u>72 hrs.</u> |
| MEDICAL CERTIFICATION | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Oblique</u> | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9 February</u> 19 <u>70</u> to <u>11 February</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>11 February</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Mark M. Appel, MD</u> | | 23B. DATE SIGNED
<u>11 February, 1970</u> | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
<u>University of Maryland Hospital</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE
<u>Feb 13/70</u> | 24C. NAME of CEMETERY or CREMATORY
<u>Arboretum M. Park</u> | 24D. LOCATION (City, town, or county) | (State)
<u>MD</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 13 1970</u> | | 25B. NAME OF REGISTRAR
<u>John E. Fisher, M.D.</u> | 25C. FUNERAL DIRECTOR
<u>U. Brooks Ruyigale</u> | |
| | | ADDRESS
<u>14137 C. Carey St</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|---|--|---|--|
| R-600 70 1749 | | 70 1749 | |
| BIRTH NO. | | 2 | |
| 1. NAME OF DECEASED (Type or Print) <i>OTELLIE RAE</i> | | 2. DATE AND HOUR OF DEATH <i>2/8/70 10:45 P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION: <i>The Johns Hopkins Hospital</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX <i>Female</i> 6. RACE <i>White</i> | | E. STREET AND NUMBER <i>3 Northland Road</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>11/27/91</i> 9. AGE (In years lost by today) <i>78</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> | |
| 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Otto Tuerke</i> | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth ?</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>215-10-02690</i> | |
| 17. INFORMANT <i>Mr. Arthur T. Rae</i> | | ADDRESS <i>3 Northland Rd. 21207</i> | |
| 18. <i>5990 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Sepsis</i> | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: <i>U.T.I</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/5</i> 19 <i>70</i> to <i>2/8</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>2/8</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Hayden Braine</i> | | 23B. DATE SIGNED <i>2/8/70</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Hayden Braine, M.D.</i> | | 23D. ADDRESS <i>The Johns Hopkins Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2/12/70</i> | |
| 24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn</i> | | 24D. LOCATION (City, town, or county) (State) <i>Woodlawn Balto. Co., Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>2/13/70</i> | | 25B. NAME OF REGISTRAR <i>John T. Stansbury, Sr.</i> | |
| 25C. FUNERAL DIRECTOR ADDRESS <i>6411 Windsor Mill Rd</i> | | | |

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A-235

70 1750

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1750

BIRTH NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
Morris Austin | | | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
2 6 70 11:15 am. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
33 Hopkins Hospital | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
2 6 70 11:15 am. | | | |
| 6. SEX
male | | | | 7. RACE
white | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
10-28-1909 | | | | 10. AGE (In years last birthday)
60 | | 11. BIRTHPLACE (State or foreign country)
MAINE | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
HARRY W. AUSTIN | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MAINTENANCE | | | | 15. MOTHER'S MAIDEN NAME
LENA E. JONAS | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 17. SOCIAL SECURITY NO.
005-12-141 | | 18. INFORMANT
MRS. MORRIS AUSTIN | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
E 881 X | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Massive pulmonary emboli
- DUE TO, OR AS A CONSEQUENCE OF: complicating fracture of leg
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | |
| 20. DATE OF OPERATION
2 | | | | 21. AUTOPSY? (Yes or No)
yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
factory | | | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
801 Philadelphia Rd. 5300 | | | | 22F. HOW DID INJURY OCCUR?
fell from ladder to floor | | | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
1 20 70 10:00a | | | | 22E. INJURY OCCURRED:
WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz M.D.
EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 2/7/70 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
CREMATION | | 24B. DATE
2-8-70 | | 24C. NAME OF CEMETERY or CREMATORY
GREEN MOUNT | | 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Joseph M. H. 7401 Belair Rd. | | ADDRESS | |

NO. 1330

NO. 1330

EXAMINER'S CERTIFICATE OF DEED

ACADEMY BUILDING

IS CORNER

OF PAPER CO.

DATE

THIRTY-THREE

OF THE YEAR

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| R-520 | | 70 1751 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1751 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) RAHNIS, EMILIE | | | |
| 2. DATE AND HOUR OF DEATH
Feb 9, 1970 5A | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
HOUSE IN THE PINES - BELVEDERE | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE BALTIMORE
B. COUNTY 2605 | | | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
HOUSE IN THE PINES - BELVEDERE | | | |
| C. CITY OR TOWN BALTIMORE | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER
311 S. ELRINO ST. | | | | | | | |
| 6. SEX F | | 7. RACE W | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. DATE OF BIRTH 5/25/1881 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. AGE (In years last birthday) 88
If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 13. FATHER'S NAME
Wenceslaus | | | | 14. MOTHER'S MAIDEN NAME
MARIE BEVAN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
217-03-2391 | | 17. INFORMANT
MRS. EMILIE BOCHENEK 311 S. ELRINO ST. | |
| 18. 433.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Cerebral thrombosis.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Congestive Heart Failure
(B) DUE TO, OR AS A CONSEQUENCE OF:
Generalized Atherosclerosis | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
1 yr
4 yrs | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 21 1970 to Feb 9 1970 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Alan B Cohen M.D. | | | | 23B. DATE SIGNED
2/7/1970 | | 23C. PHYSICIAN'S NAME (Type)
Alan B Cohen M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2/12/70 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
James E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
BOBROWSKI | | 25D. ADDRESS
2818 E. Baltimore St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| G-416 | | 70 1752 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 70 1752 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) ANN DOLORES GILBERT | | | | 2. DATE AND HOUR OF DEATH
2/9/70 5:20 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNIV. Md. Balt, Md. | | | | | | A. STATE
MD. | | 8. COUNTY
ANN ARUNDEL | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | | C. CITY OR TOWN
GLEN BURNIE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | E. STREET AND NUMBER
8 GILMORE ST | | | |
| 5. SEX
F | | 6. RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/18/26 | | 9. AGE (in years lost birthday)
43 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (State or foreign country)
USA Md. | | 12. CITIZEN OF WHAT COUNTRY
USA | | | |
| 13. FATHER'S NAME
EDWARD SHIPLEY | | | | | | 14. MOTHER'S MAIDEN NAME
FRANCES (unknown) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MR. O'NEAL (HUSBAND) GILBERT | | ADDRESS
SAME AS 44 | | | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
MYOCARDIAL INFARCT | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 DAYS | |
| | | | | | | (B) PULM & CEREBRAL EMBOLI | | 2 DAYS | |
| | | | | | | (C) CHRONIC ATRIAL FIBRILLATION | | 4 YRS. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | RHEUMATIC HEART DISEASE | | 25 YRS | |
| 19A. DATE OF OPERATION
3/2/4/70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
MITRAL VALVULAR STENOSIS | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/7/70 19 70 to 2/9 19 70
that (I) (we) last saw the deceased alive on 2/9 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Howard Wallach, MD | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
2/9/70 5 PM | |
| 23C. PHYSICIAN'S NAME (Type)
HOWARD WALLACH M.D. | | | | | | 23D. ADDRESS
UNIV. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
FEB 12 1970 | | 24C. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL Cem. | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
E. B. Fleming | | ADDRESS
Sanatation General Home | | | |

CONFIDENTIAL
F W
x

HOWEVER OWN HOME
EDWARD SHIPLEY

NO MORE

USA 194

FRANCIS (MARRIED)

EDWARD SHIPLEY

EDWARD SHIPLEY

EDWARD SHIPLEY

EDWARD SHIPLEY

EDWARD SHIPLEY

EDWARD SHIPLEY

EDWARD SHIPLEY

EDWARD SHIPLEY

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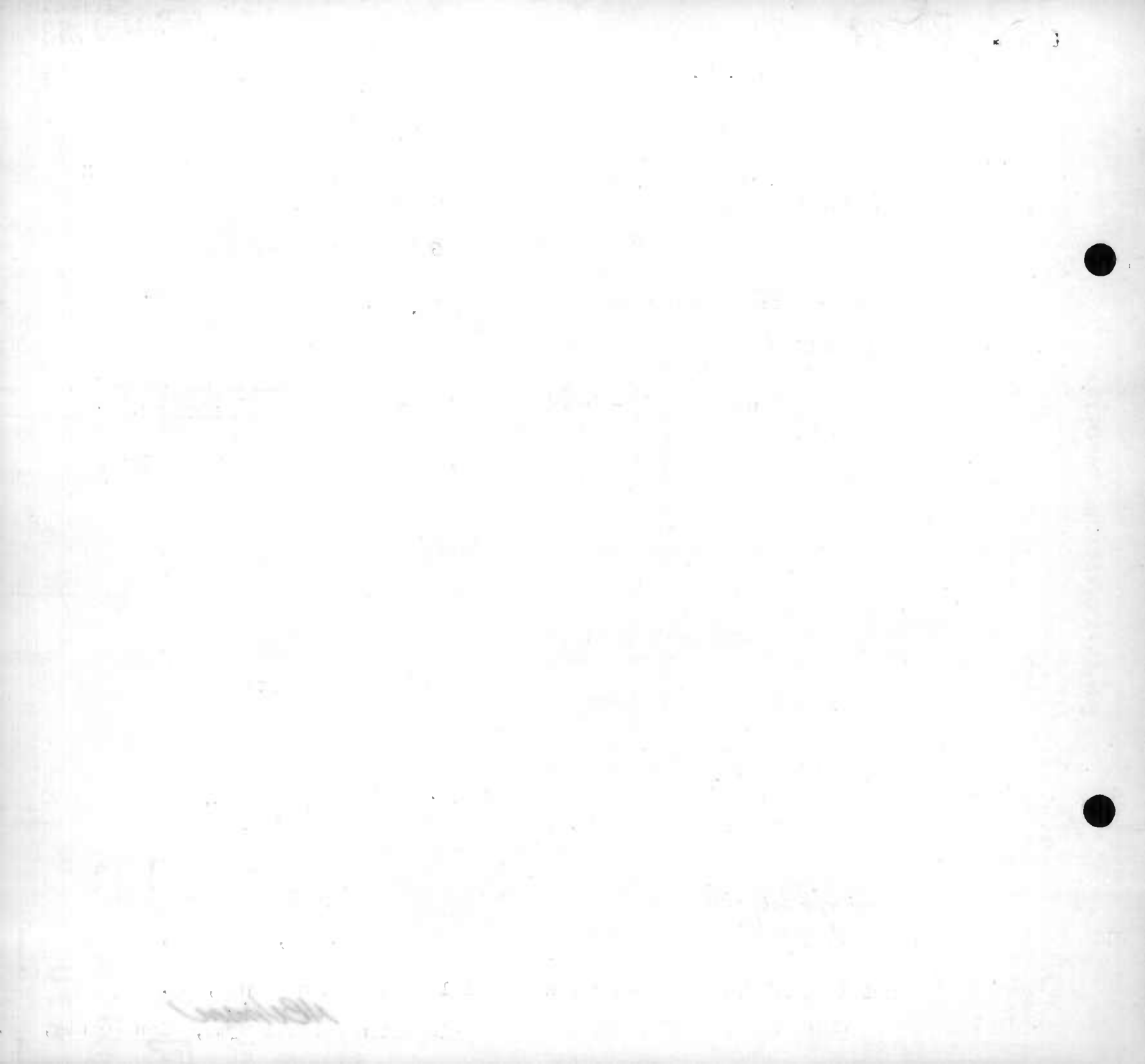
EDWARD SHIPLEY

EDWARD SHIPLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|--------------|---|---|---|---|
| T-200 70 1753 | | 70 1753 | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Omar W. L. Tice | | February 9, 1970 6: 50 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
US Public Health Service Hospital
2X 3100 Wyman Parkway | | | A. STATE
Md. B. COUNTY
BALTO. CO. 5200 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
Linthicum Heights | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | E. STREET AND NUMBER
457 Gayle Drive | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/6/09 | 9. AGE (In years last birthday)
60 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chief Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY
Seafarer | 11. BIRTHPLACE (State or foreign country)
Phila. Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Cyrus Tice | | | 14. MOTHER'S MAIDEN NAME
Nora Shivley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None | | 16. SOCIAL SECURITY NO.
086-12-5640 | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | |
| 18. 185X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Carcinoma of the prostate
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 27 1970 to Feb. 9 1970, that (I) (we) last saw the deceased alive on Feb. 9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Peter J. Philpott MD | | | | 23B. DATE SIGNED
2/10/70 | |
| 23C. PHYSICIAN'S NAME (Type)
Peter J. Philpott, Surgeon (R) | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/12/70 | | 24C. NAME of CEMETERY or CREMATORY
Glen Haven Memorial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Glen Burnie, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor MD | | 25C. FUNERAL DIRECTOR
Singleton Funeral Home | |
| | | | | ADDRESS
Glen Burnie, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|---|--|---|--|---|--|
| B-535 70 1754 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. [REDACTED] | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Elizabeth Bindeman</i> | | 2. DATE AND HOUR OF DEATH
<i>2/6/70</i> | | 70 1754
10 30 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>90 Harbor View Nursing Home</i>
<i>1213 Light St</i> | | | | A. STATE <i>Md</i> B. COUNTY <i>anne arundel</i> <i>5200</i> | | | |
| | | | | C. CITY OR TOWN
<i>Balto Md 21227</i> | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<i>98 Smith Road #410 Cleveland Rd</i>
<i>Penthouse</i> | | | |
| 5. SEX
<i>7</i> | 6. RACE
<i>N</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>2/4/78</i> | 9. AGE (In years lost birthday)
<i>92</i> | 10. Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>House Work (Ret)</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | |
| 13. FATHER'S NAME
<i>Frederick Ralph</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Elizabeth Nell</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Daughter</i> | | ADDRESS
<i>410 Cleveland Rd</i>
<i>Penthouse Lights</i> | |
| 18. <i>412.4 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<i>Cerebro Vascular Accident ?</i>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <i>Arteriosclerotic Cardiac Vascular</i>
DUE TO, OR AS A CONSEQUENCE OF: <i>Dissect</i>
(C) <i>Chronic Brain Syndrome</i> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April</i> 19 <i>69</i> to <i>February 6</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>2-6</i> 19 <i>70</i> and that (in my our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Rolando V. Goco, M.D.</i> | | | | 23B. DATE SIGNED
<i>2-7-70</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Rolando V. Goco, M.D.</i> | | | | 23D. ADDRESS
<i>1213 Light St.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2/10/70</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>New Cathedral Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 13 1970</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Bailey, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Singleton Funeral Home</i> | | ADDRESS
<i>Alon Buerke</i> | |

House No. 17 (17) New House

18
2
Baltimore, Md

11.2.1

Mr. [unclear]

James
2140 New Catholic Cemetery Baltimore
2140 New Catholic Cemetery Baltimore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1755 | |
|---|---------|--|------------------|--|----------------------------|
| <div style="display: flex; justify-content: space-between;"> D-166 70 1755 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Rose DiBerardo | | February 7, 1970 7:30 AM. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | 8. COUNTY | |
| Maryland | | Maryland | | 2608 | |
| C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | | |
| Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER | | 3902 E. Pratt Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| Female | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8/21/92 | 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | Home | | Abruzzi, Italy | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Pasquale DiBerardo | | Giacinta Antonini | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 213-07-4126 D | | Mr. Anthony DiBerardo | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| 410.9 I | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CORONARY THROMBOSIS | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) ARTERIOSCLEROTIC C.V.D. | | | |
| ANTECEDENT CAUSES | | (C) ... | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | PERNICIOUS ANEMIA 10 YRS. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 11-11-61 19 to 2-9-70 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| John Constantini | | 2-9-70 | | JOHN CONSTANTINI, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/10/70 | | Holy Redeemer | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 13 1970 | | John E. Taylor, M.D. | | 263 S. Conkling St | |

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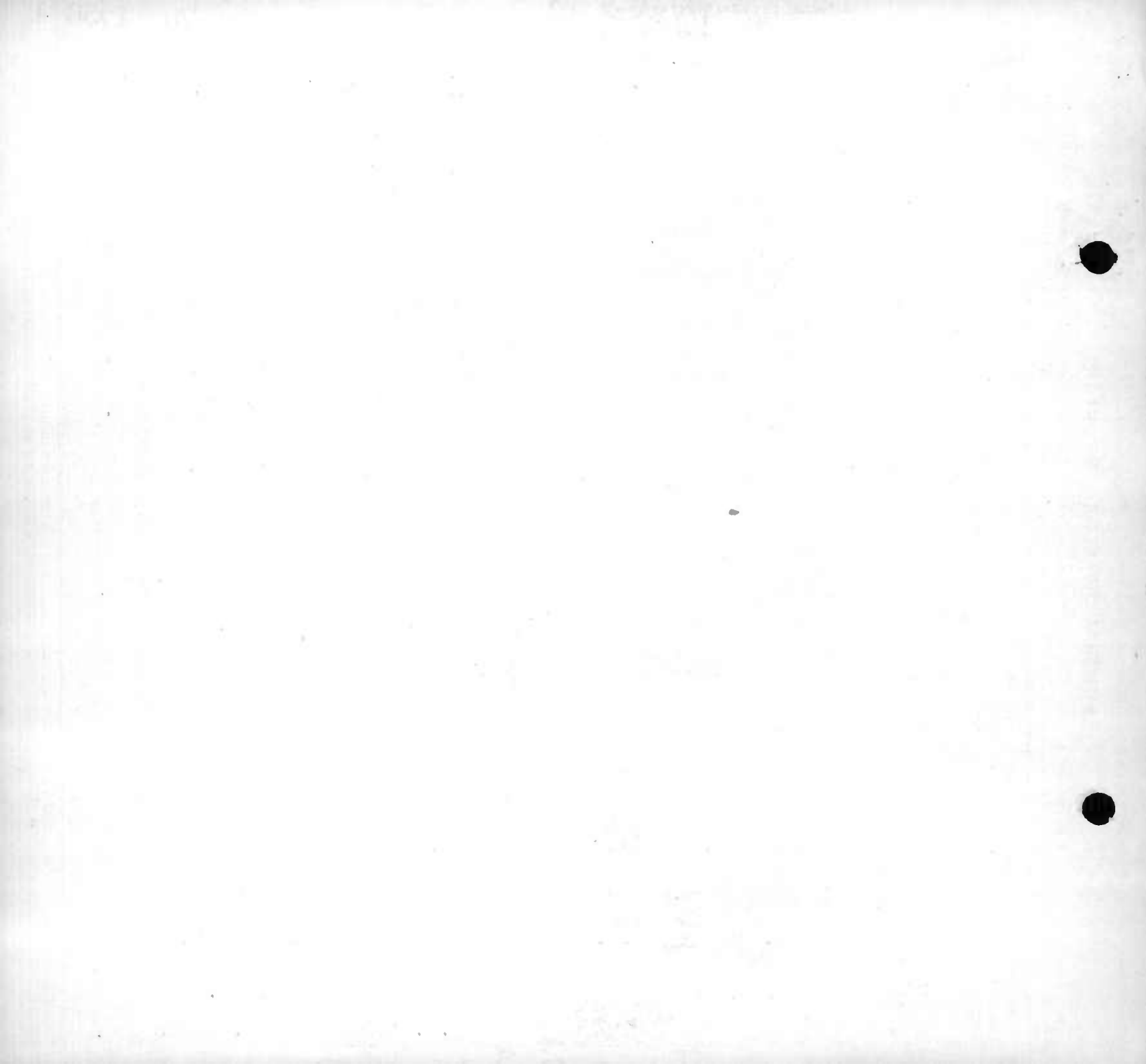
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 70 1756 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1756 | |
|---|---|---|--|--|----------------------------------|
| BIRTH NO. | | REG. NO. | | 70 1756 | |
| 1. NAME OF DECEASED
(Type or Print) | | BAKER, Alma S. | | 2. DATE AND HOUR OF DEATH
Jan Feb 10 1970 10:20 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY | | Maryland 909 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 33 The Johns Hopkins Hospital | | Baltimore | | | |
| E. STREET AND NUMBER | | 1324 Holbrook Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. AGE (In years last birthday) |
| Female | Negro | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 1/27/14 | 56 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Virginia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Thomas Baker | | Hattie Woodson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Julia Booker 1434 Holbrook St. | |
| 18. 199.1 I | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | Adenocarcinoma 6 months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Peptic ulcer disease | | 20 years | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| Feb 10, 1970 | 2/6 vascular accident | Yes | NO | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 3 1970 to Feb 10 1970, that (I) (we) last saw the deceased alive on Feb 2 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Thomas R. Griggs MD | | Feb 10, 1970 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Thomas R. Griggs, M.D. | | The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 2/14/70 | | | Dillwyn, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 13 1970 | | Robert E. Fisher, M.D. | | W.C. March 928 E. North Ave. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

| | | | | | |
|---|-------------------------|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) E. GEORGE PHILLIPS | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 3. DATE PRONOUNCED DEAD
February 11, 1970 | | Hour 11:25 A. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 807 | | | | | |
| 6. SEX
Male | 7. RACE
Negro | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
10-18-25 | | 10. AGE (In years last birthday)
44 | | E. STREET AND NUMBER
1305 N. Bond Street | |
| 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
James Phillips | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME
Hattie | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WWII | | 17. SOCIAL SECURITY NO.
243-20-3566 | | 18. INFORMANT
Mary I. Phillips | |
| 19. 412.4 - 250.9
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Diabetes Mellitus | | CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23.
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D.
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 2/11/70 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Balto National Cem | |
| 24D. LOCATION (City, town, or county) (State)
Balto., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
W.C. March | |
| | | | | ADDRESS
928 E. North Ave. | |

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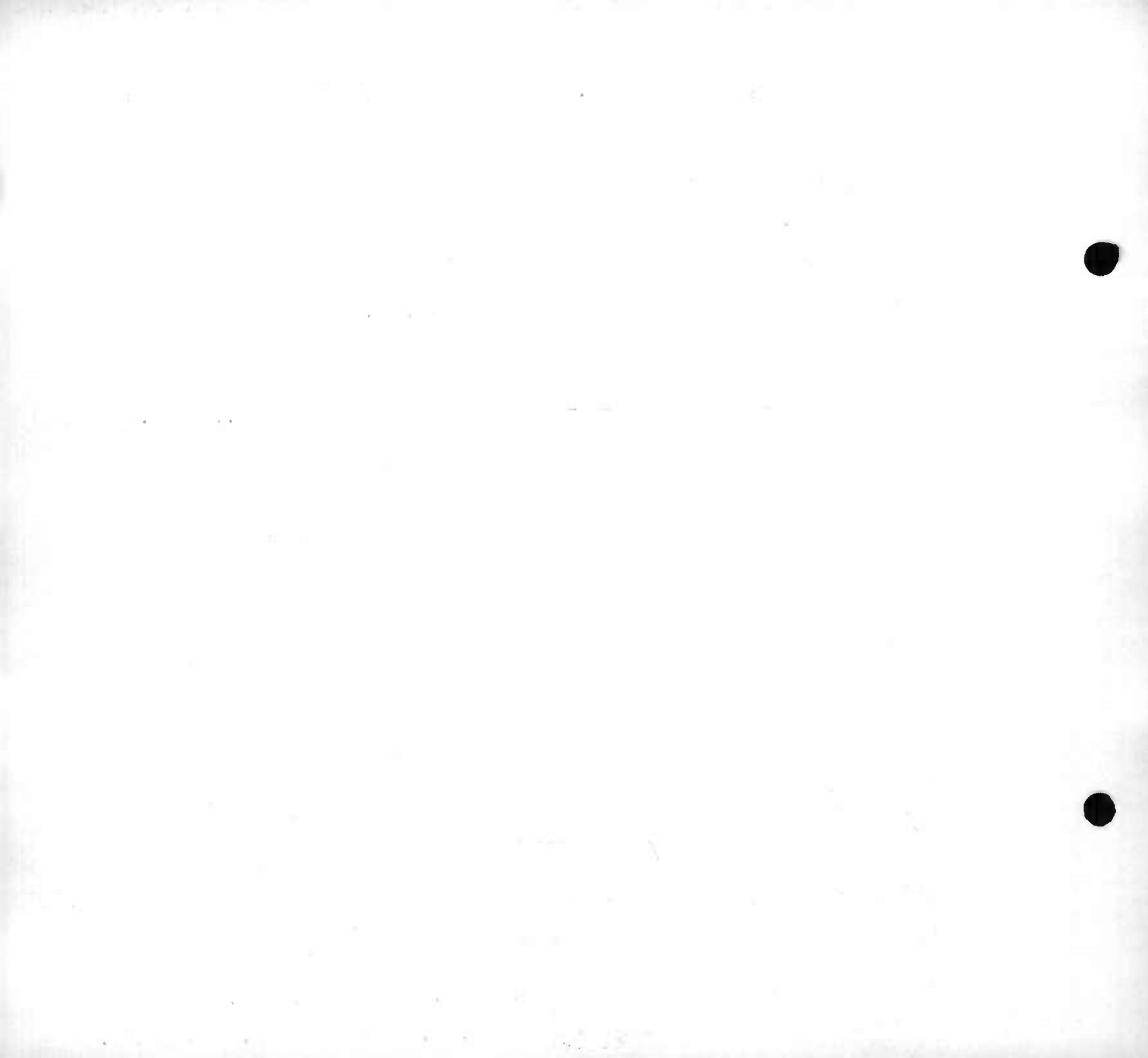
STATE OF NEW YORK

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 70 1758 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1758 | |
|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) HUFF, John Edward Sr. | | | | 2. DATE AND HOUR OF DEATH
2/9/70 9:00 P | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 1203 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
23 Veterans Administration Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
3900 Loch Raven Boulevard | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
Male | | 6. RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3/21/19 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Porter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday)
50 | | 11. BIRTHPLACE (State or foreign country)
Atlanta, Ga. | |
| 13. FATHER'S NAME
Odis Huff | | | | 14. MOTHER'S MAIDEN NAME
Fannie Peoples | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 7/18/44 - 12/4/44 | | 16. SOCIAL SECURITY NO.
212-14-9912 | | 17. INFORMANT
VA Hospital Records | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
I
Hepatic encephalopathy
3 days
Cirrhosis (laennec)
10 years
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (mostly medical examined)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 3rd 19 70 to February 9th 19 70 that (I) (we) last saw the deceased alive on February 9th 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Ronald S. Pototsky M.D. | | | | 23B. DATE SIGNED
February 10, 1970 | | 23C. PHYSICIAN'S NAME (Type)
RONALD S. POTOTSKY M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/13/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Balto National Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
E. Taylor M.D. | | 25C. FUNERAL DIRECTOR
W. C. March | | | |
| ADDRESS
928 E. North Ave. | | | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

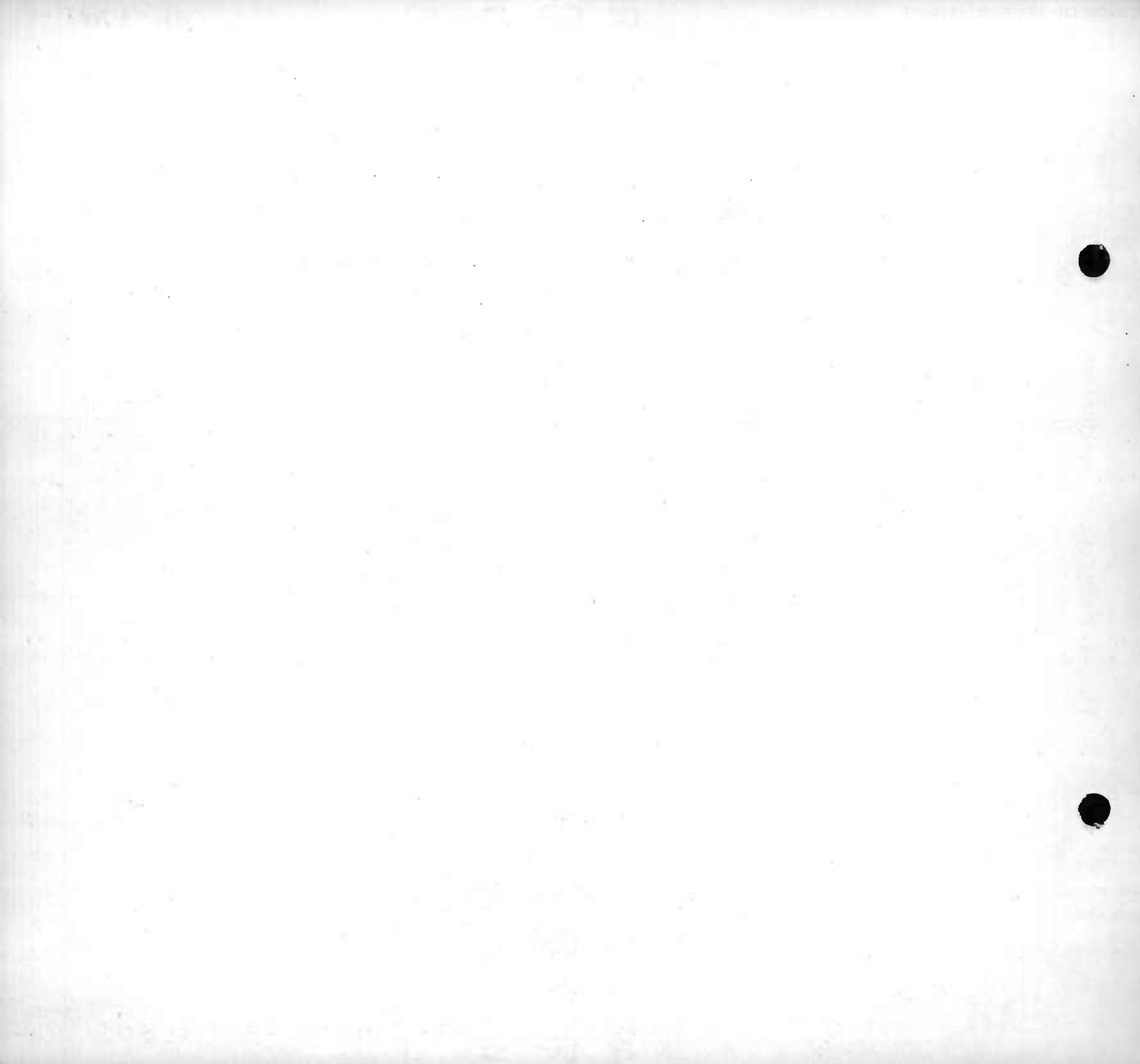
| | | | | | |
|--|---------|---|------------------|---|---|
| 70 1759 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. 70 1759 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ZAMERSKI, Theodore Joseph | | February 12, 1970 2:15 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | Maryland | | | |
| 23 Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
410 S. Regester Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| Male | White | | 10/14/18 | 51 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Painter | | Self-employed signs | | Baltimore, Maryland | |
| 13. FATHER'S NAME
Edward Zamerski | | 14. MOTHER'S MAIDEN NAME
Mary Czosnowski | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 6/8/44 - 2/17/46 | | 16. SOCIAL SECURITY NO.
215-09-2193 | | 17. INFORMANT
VA Hospital Records
3900 Loch Raven Blvd., Balto., Md 21218 | |
| 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
Chronic Malnutrition
DUE TO, OR AS A CONSEQUENCE OF: | | 6 months | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Chronic Alcoholism
DUE TO, OR AS A CONSEQUENCE OF: | | Many Years | |
| | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Pulmonary Tuberculosis, far-advanced, bilateral cavitory, cultures pending probably inactive | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from February 5th 19 70 to February 12th 19 70 that (I) (we) lost saw the deceased alive on February 12th 19 70 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Michael E. Grandis M.D.</i> | | 23B. DATE SIGNED
February 12, 1970 | | 23C. PHYSICIAN'S NAME (Type)
Michael E. Grandis M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Rosary | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. ADDRESS
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | 24F. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR
M. J. SADOWSKI & SONS, 1808 EASTERN AVE | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|-----------------------------|---|---|--|---|
| 70 1760 | | 70 1760 | | 70 1760 | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) ELLA POWELL | | | 2. DATE AND HOUR OF DEATH
FEB. 12, 1970 9:00 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY 2006 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 ST. AGNES HOSPITAL WILKENS & CATON AVES. | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
2730 WILKENS AVE | | |
| 5. SEX
FEMALE | 6. RACE
CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-8-1898 | 9. AGE (In years last birthday)
71 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
JOSEPH | | | 14. MOTHER'S MAIDEN NAME
FAITH | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MRS. JEAN TAWA | |
| | | | | ADDRESS
SAME | |
| 18. 4-10-9 I CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Coronary artery occlusion
Coronary artery sclerosis
(B) DUE TO, OR AS A CONSEQUENCE OF:
Atherosclerotic CardioVascular disease
(C) | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 1954 to Feb. 12, 1970 , that (I) last saw the deceased alive on Jan 2, 1970 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. cleared & medical examiner | | | | | |
| 23A. SIGNATURE
Harry L. Knipp, MD | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
2-13-70 | |
| 23C. PHYSICIAN'S NAME (Type)
HARRY L. KNIPP MD | | 23D. ADDRESS
#116 Edmonson Ave. Balt. Md. 21229 | | | |
| 24A. BURIAL OR REMOVAL (Specify)
BURIAL | | 24B. DATE
2-16-70 | | 24C. NAME OF CEMETERY OR CREMATORY
BALTO. NATIONAL | |
| | | | | 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, MD. | | 25C. FUNERAL DIRECTOR
G. L. SCHWAB | |
| | | | | ADDRESS
2101 FRED'K AVE. MD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 70 1761 |
|--|--|---|--|--|
| BIRTH NO. B-255 70 1761 | | 1. NAME OF DECEASED
(Type or Print) Gerard H. Buchanan | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 2. DATE AND HOUR OF DEATH
1/30/70 9:25 P.M. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
38 University of Maryland Hosp
Baltimore, Md. | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 5. SEX M 6. RACE W | | E. STREET AND NUMBER
316 Tollgate Rd | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9/19/08 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook | | 9. AGE (In years last birthday)
61 | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Md | | |
| 13. FATHER'S NAME
Lee Buchanan | | 12. CITIZEN OF WHAT COUNTRY?
US | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 14. MOTHER'S MAIDEN NAME
Carrie Collins | | |
| 16. SOCIAL SECURITY NO.
220-14-6607 | | 17. INFORMANT
Patients | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
E. coli sepsis | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF
Staphylococcal Sepsis | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) starting the UNDERLYING CONDITION last.
Severe Diabetes Mellitus | | (B) DUE TO, OR AS A CONSEQUENCE OF:
Cellulitis thrombophlebitis leg | | |
| | | (C) 2° Burns legs & feet | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)
Severe Diabetes Mellitus | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
841 5609 Haddon Ave. Baltimore, Md. | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
841 5609 Haddon Ave. Baltimore, Md. | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
1 27 70 ? | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
fell asleep & feet propped on chair right to stage - burned feet | | |
| 22. I certify that (I) (the hospital) attended the deceased from 1/30/70 to 1/30/70 and that (I) (we) last saw the deceased alive on 1/30/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Michael A. Ellis M.D. | | | | 23B. DATE SIGNED
1/30/70 |
| 23C. PHYSICIAN'S NAME (Type)
Michael A. Ellis M.D. | | 23D. ADDRESS
1000 N. ... | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-4-70 | | 24C. NAME of CEMETERY or CREMATORY
St. Alphonsus |
| 24D. LOCATION (City, town, or county) (State)
Woodstock, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Charles R. Law | | |
| 25D. ADDRESS
802 Madison Ave. | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X REG. NO. 70 1762 | |
|---|-------------------------|---|--|--|---|
| G-620 70 1762 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED
(Type or Print)
Mary Josephine George | | | 2. DATE AND HOUR OF DEATH
2-8-70 2:00 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
37 MERCY HOSPITAL, INC | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN Timonium D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER Stella Maris | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/23/1888 | 9. AGE (In years last birthday)
81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
William Gahan | | | 14. MOTHER'S MAIDEN NAME
Mollie Daily | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-46-2629 | | 17. INFORMANT ADDRESS
Louise S. Manger, 4401 Roland Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cardiorespiratory failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Chronic Brain Syndrome
Committted Fracture (L femur) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Nursing Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Stella Marie Mrs. Johnson | |
| 21D. TIME OF INJURY (APPROX.)
2-7-70 6:30 | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
fall | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-7-1970 to 2-8-1970 that (I) (we) last saw the deceased alive on 2-8-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Randhir P. Sinha | | | 23B. DATE SIGNED
2-8-70 | | 23C. PHYSICIAN'S NAME (Type)
RANDHIR P. SINHA, M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
2/12/70 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral |
| 24D. LOCATION (City, town, or county)
Baltimore | | | 24E. ADDRESS
MERCY HOSPITAL, Balto. Md 21202 | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | | 25B. NAME OF REGISTRAR
H. W. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS
H. W. Jenkins & Sons Co., 4905 York Rd. Balto., Md. 21212 |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. 70 1763 | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) YOLANDA TRUSTY | | | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/> 2 9 70 | | | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour February 9, 1970 1:49 p.m. | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Provident Hospital D.O.A. | | | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 1403 | | | | | | | |
| 6. SEX Female | | 7. RACE Negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 9. DATE OF BIRTH 12/22/69 | | 10. AGE (In years last birthday) 6 weeks | | 11. BIRTHPLACE (State or foreign country) Baltimore Md | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME William Trusty | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 14B. KIND OF BUSINESS OR INDUSTRY | | | | 15. MOTHER'S MAIDEN NAME Stella Mcray | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT Mother, same ADDRESS | | | | | |
| 19. CAUSE OF DEATH
E911X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | (A) IMMEDIATE CAUSE Aspiration asphyxia
DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20A. DATE OF OPERATION 2 | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) YES | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.) Home | | | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 504 Baker Street | | | |
| 22D. TIME OF INJURY (APPROX.) 2 9 70 ? | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? Subject aspirated on food | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D.
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>

DATE SIGNED 2/10/70 | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/14/70 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 13 1970 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Adolphus Halstead | | 25D. ADDRESS 1206 W north Ave | | | | | |

NO 1203

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

TO THE DIRECTOR OF THE BUREAU OF THE ARMY
FROM THE DIRECTOR OF THE BUREAU OF THE ARMY
SUBJECT: [Illegible]
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or official communication.]

U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

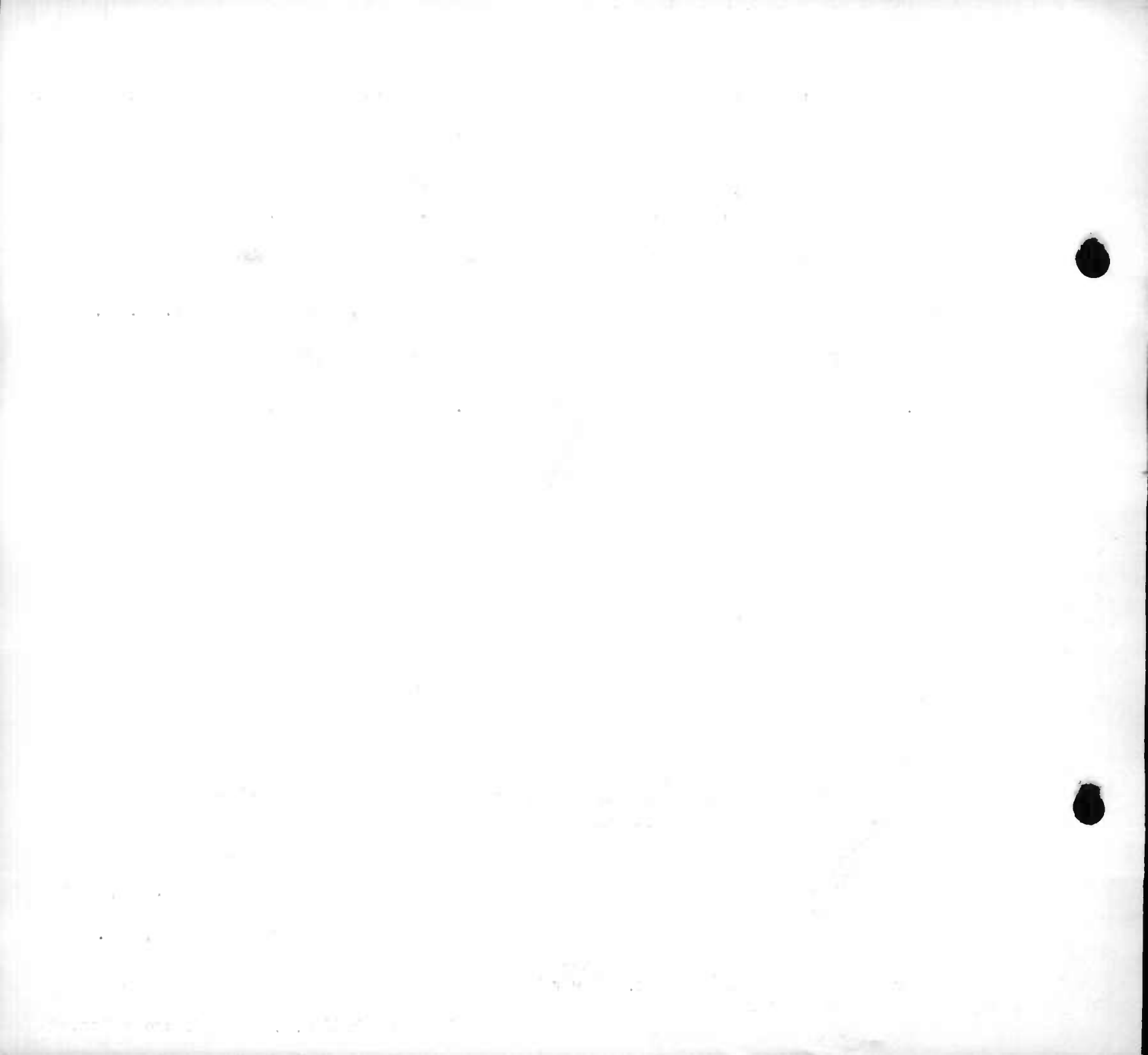
| | | | | | | | |
|--|-------------------------|---|------------------------------------|---|--|---|--|
| S-530 | | 70 1764 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1764 | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Smith, Pansy</i> | | | | 2. DATE AND HOUR OF DEATH
<i>2-11-70 12:30 A.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>1605</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>34 Bon Secours Hospital</i> | | | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | E. STREET AND NUMBER
<i>2111 Edmondson Avenue</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>Negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>8/25/15</i> | 9. AGE (In years, lost birthday)
<i>54</i> | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>South Carolina</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Smith, James</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>?</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Admission Sheet</i> | | ADDRESS | |
| 18. <i>410.9 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
<i>Acute MI.</i>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Myocardial Ischemia, & Atherosclerosis</i>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<i>@ failure</i>
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Years</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2-7-70</i> to <i>2-11-70</i> .
that (I) (we) last saw the deceased alive on <i>2-11-70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Varah Varasubini, M.D.</i> | | | | 23B. DATE SIGNED
<i>2/11/1970</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>VARAH VORASUBIN, M.D.</i> | | 23D. ADDRESS
<i>Bon Secours Hospital, Balto, Md.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2/14/70</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>MT Auburn Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md</i> | |
| 25A. DATE RECEIVED BY HEALTH DEPT.
<i>FEB 13 1970</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Talley, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Adolphus Halstead</i> | | ADDRESS
<i>1206 W North Ave</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>70 1765</u> | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. <u>P-362</u> <u>70 1765</u> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Peters, Mildred</u> | | | 2. DATE AND HOUR OF DEATH
<u>2-11-70</u> <u>6:15</u> P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>1501</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Provident Hospital</u>
<u>1514 Divison Street</u>
<u>Baltimore, Maryland 21217</u> | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<u>1346 N. Fremont Ave.</u> | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8-28-1901</u> | 9. AGE (In years last birthday) <u>68</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Balto, Maryland</u> | |
| 13. FATHER'S NAME
<u>George Holmes</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Irene Tolbert</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]
<u>No.</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mr. Charles Peters-Husband</u> ADDRESS <u>Same</u> | |
| 18. <u>250.91</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Pulmonary Congestion</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>Diabetes mellitus</u> | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) _____
(C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-5-70</u> to <u>2-11-70</u> that (I) (we) last saw the deceased alive on <u>2-11-70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | | | 23B. DATE SIGNED
<u>Feb. 12, 1970</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>[Signature]</u> | | | | 23D. ADDRESS
<u>1514 Divison Street Baltimore, Md.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2-14-70</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Auburn</u>
<u>Mt. XXXXX Cemetery</u> | |
| 24D. LOCATION
<u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 13 1970</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>MORTON & DYETT F.H.</u> ADDRESS <u>1701 Laurens Street</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|---------------------|--|---|---|---|
| H-520 70 1766 | | | | 70 1766 | |
| BIRTH NO. | | | | 2 | |
| 1. NAME OF DECEASED
(Type or Print) ANNIE R. HINES | | | 2. DATE AND HOUR OF DEATH
FEB. 10, 1970 3:25 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY 1501 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
MONTEBELLO STATE HOSPITAL | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
1350 FREMONT AVE | | | | | |
| 5. SEX
F | 6. RACE
B | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-9-04 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Florence, South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
Jackson Anderson | | 14. MOTHER'S MAIDEN NAME
Lou Nelly | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. Ole Hines | |
| 18. 250.9 I | | CAUSE OF DEATH | | ADDRESS
1350 N. Fremont Ave | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CARDIAC ARREST | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
| |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ARTERIOSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF: | | 8 YRS. | |
| | | (C) DIABETES MELLITUS | | 10 YRS. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | URINARY TRACT INFECTION. | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-20 19 70 to 2-10 19 70 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2-10 19 70 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Irving L. Cooperstein | | 23B. DATE SIGNED
Feb. 10, 1970 | | 23C. PHYSICIAN'S NAME (Type)
IRVING L. COOPERSTEIN | |
| 23D. ADDRESS
MONTEBELLO STATE HOSP., BALTO., MD. | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2/14/70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cem. | | 24D. LOCATION (City, town, or county) (State)
A.A. Co., Md | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Robert E. Taylor | | 25D. ADDRESS
1701 LAURENS ST. | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

| | | | | |
|--|-----------------------------|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
ZULA MAE ANDERSON | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year
February 11, 1970 | | Hour
M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 7 E. Montgomery | | 3. DATE PRONOUNCED DEAD
Month Day Year
February 11, 1970 | | Hour
9:40 P.M. |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland | | B. COUNTY
2201 | | |
| 6. SEX
Female | 7. RACE
Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore |
| 9. DATE OF BIRTH
9-23-09 | | 10. AGE (In years lost birthday)
60 | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | E. STREET AND NUMBER
7 E. Montgomery |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 14B. KIND OF BUSINESS OR INDUSTRY | | 13. FATHER'S NAME
Henry Moore |
| 15. MOTHER'S MAIDEN NAME
Lizzie Moore | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Frank C. Anderson | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
412.41 | | CAUSE OF DEATH
Arteriosclerotic cardiovascular disease | | ADDRESS
4037 Bowman Ave. |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL EXAMINER'S NAME (Type)
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
February 12, 1970 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
2-17-70 | 24C. NAME OF CEMETERY or CREMATORY
Community Cemetery | | 24D. LOCATION (City, town, or county) (State)
Tarboro, N. Carolina |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Charles A. Rice |
| 25D. ADDRESS
661 W. Barre St. | | | | |

ACADEMY BOND

W. H. FARRER CO.

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|--|--|--|--|--|
| 11-250 70 1769 | | 70 1769 | | | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| Thomas F. McKenna | | Feb. 9, 1970 About 1 A.M. | | FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | |
| 00 702 Dorchester Rd. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 9-22-06 | | 9. AGE (In years last birthday) 63 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John KcKenna | |
| 14. MOTHER'S MAIDEN NAME Marie Healey | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-01-2516 | |
| 17. INFORMANT Patricia M. McKenna-702 Dorchester Rd-21229 | | 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest | | seconds | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis | | minutes | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | Coronary Artery Disease - Angina | | 2-3 years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from Jan 19 62 to 2/9 19 70, that (I) last saw the deceased alive on 3/20 19 69 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James J. Nolan | | 23B. DATE SIGNED 2/10/70 | | 23C. PHYSICIAN'S NAME (Type) James J. Nolan | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-12-70 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | |
| 24D. LOCATION Baltimore, Maryland | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229 | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 13 1970 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |

Statement from Attending Physician
2-17-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| D-620 70 1770 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 70 1770 | |
|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | |
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) William F. Dorsey Sr. | | | | 2-9-70 M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
St. Agnes Hospital | | | | A. STATE
Md. | | B. COUNTY
Balto. | |
| 5. SEX
M | | | | 6. RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Car Inspector | | | | 10B. KIND OF BUSINESS OR INDUSTRY
B & O Railroad | | 8. DATE OF BIRTH
8-16- 1893 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | | 9. AGE (In years last birthday)
76 | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Dorsey | | | | 14. MOTHER'S MAIDEN NAME
Margaret | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Dorothy Zentgraf 3405 Centennial Ln. 21043 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF
Acute coronary occlusion with MIO | | minutes | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
Advances arteriosclerosis with arteriosclerotic cardiovascular disease. myocardial | | years | |
| | | | | (C) Acute virus infection | | days | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 19 70 to Feb. 9 19 70, that (I) (we) last saw the deceased alive on Feb. 9 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Henry Armanas | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
Feb. 10. 1970 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Henry Armanas | | | | 23D. ADDRESS
1934 Wilkens Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-12-1970 | | 24C. NAME OF CEMETERY or CREMATORY
Western Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
H.H.ubbard | | 25C. FUNERAL DIRECTOR
H.H.ubbard Funeral Home | | ADDRESS
4107 Wilkens Ave | |

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And what
is the
result of
the
experiment?

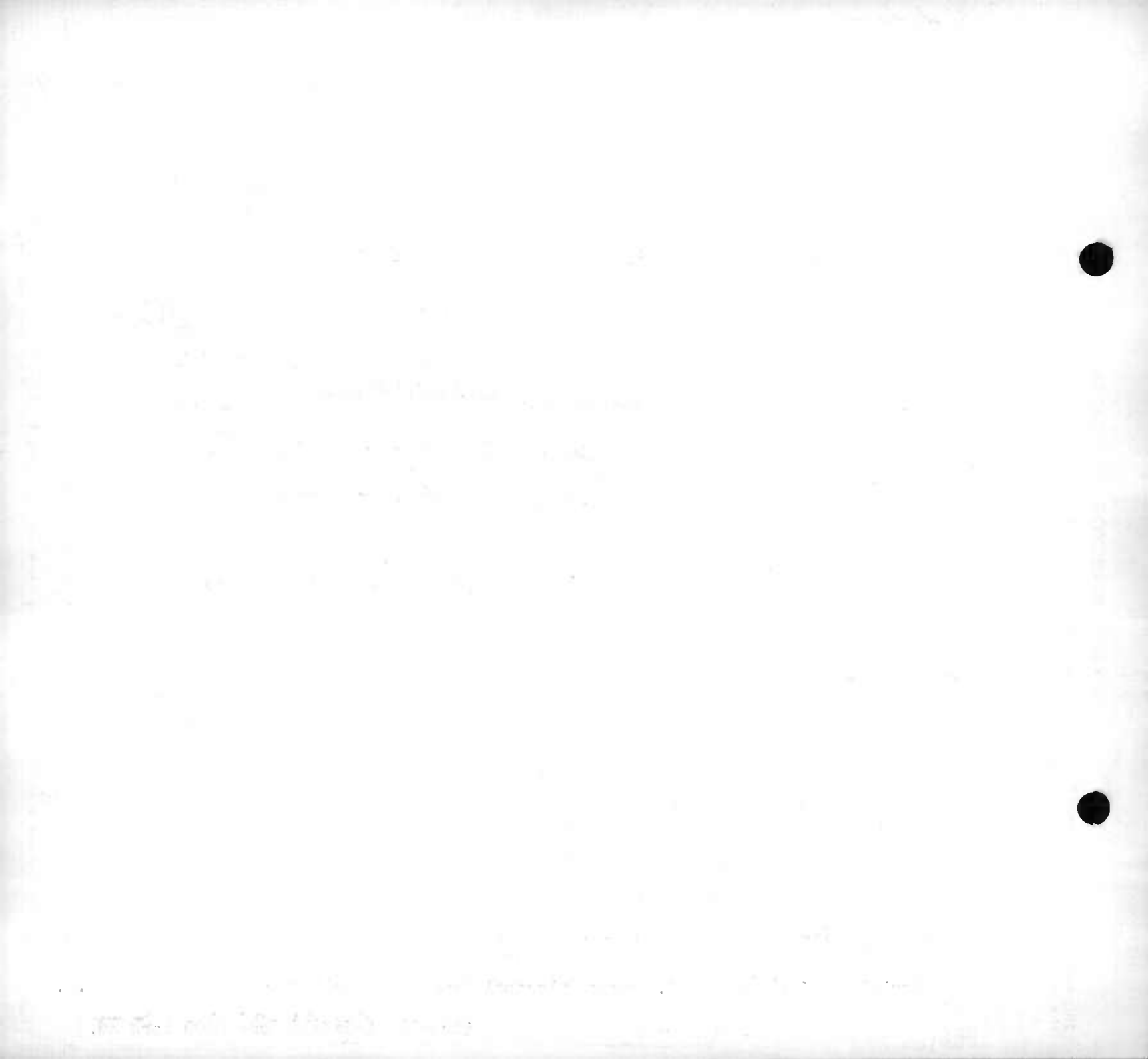
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✓ - 1000000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 70 1771 |
|--|----------------------------|---|---|---|---|
| H-520 70 1771 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>AUGUSTAW HAYNES</u> | | | 2. DATE AND HOUR OF DEATH
<u>2-3-70</u> <u>2:00 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>49 North Charles Glen Hosp</u> | | | A. STATE <u>Md</u> B. COUNTY <u>BALTO</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
<u>6608 GLEN BARR</u> | | | BARR <u>count Balto 2nd St</u> | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-1-1870</u> | 9. AGE (in years last birthday)
<u>99</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>New York</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>JOEL WICKER</u> | | 14. MOTHER'S MAIDEN NAME
<u>AUGUSTA RUSSELL</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>200365499 J1</u> | | 17. INFORMANT
<u>Richard B. Haynes</u> ADDRESS <u>SAME</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<u>Septicemia & pancreatitis</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>pyelonephritis & calculus</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>—</u> | | 20A. AUTOPSY? (Yes or No)
<u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
<u>yes</u> | |
| 21D. TIME OF INJURY (APPROX.)
1 (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-29</u> 19 <u>70</u> to <u>2-3</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2-3</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>M. Melencio Ventura</u> | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type)
<u>MELENCIO VENTURA</u> | | | 23D. ADDRESS
<u>NORTH CHARLES GLEN Hosp</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>2/6/70</u> | 24C. NAME of CEMETERY or CREMATORY
<u>St. Marys Episcopal Cemetery</u> | | 24D. LOCATION (City, town, or county)
<u>Burlington</u> | (State)
<u>N.J.</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 10 1970</u> | | 25B. NAME OF REGISTRAR
<u>JOSE F. B. M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Mitchell Wiedefeld Home</u> | |
| | | | | ADDRESS
<u>6500 York Rd.</u> | |

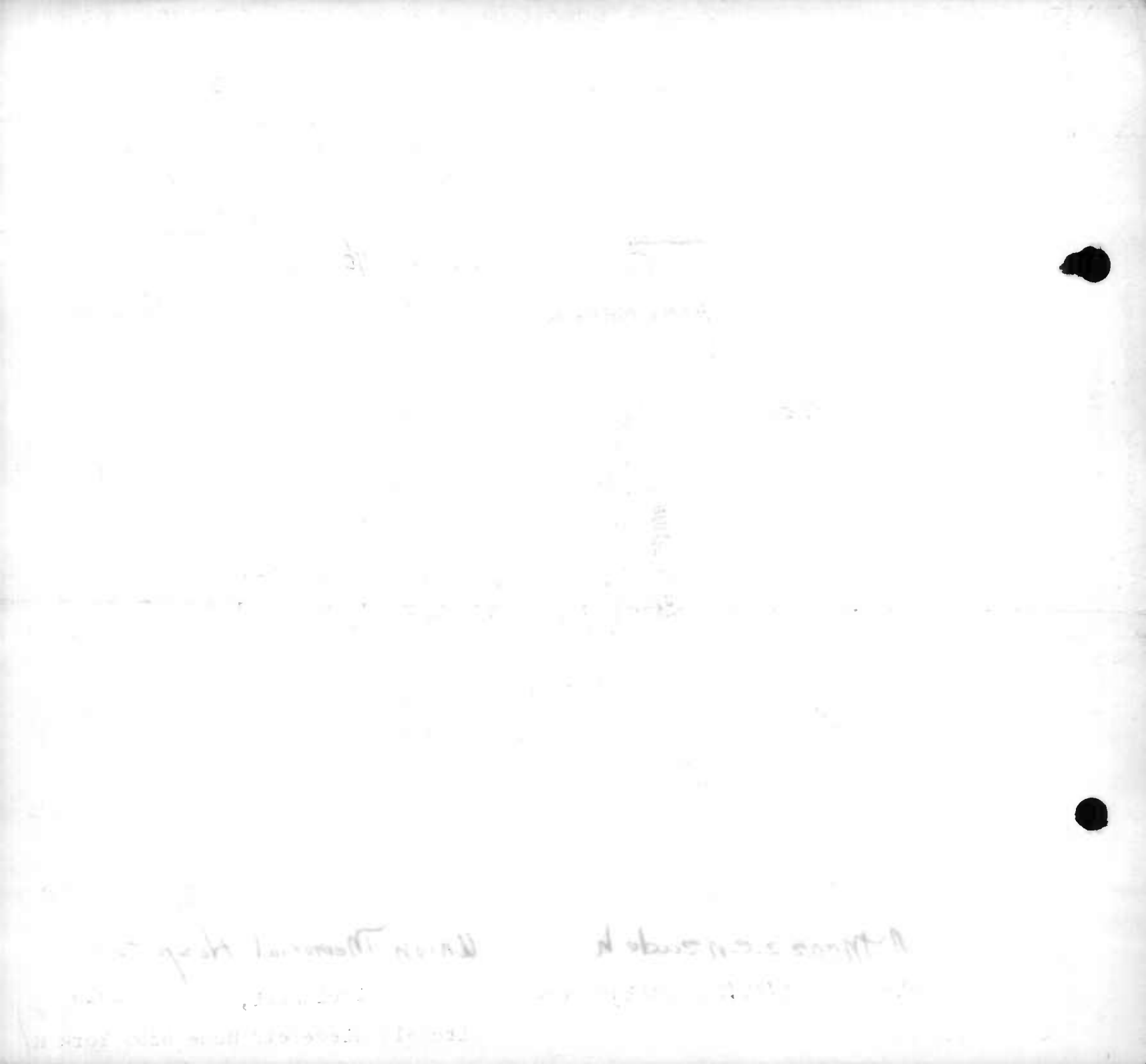


Approval (Released by Medical Examiner)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|----------------------|--|--|--|---|
| BIRTH NO. D-120 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1772 | |
| 1. NAME OF DECEASED
(Type or Print) DAVIS, ANNE M. | | | 2. DATE AND HOUR OF DEATH
2-20 PM 2/10/1970 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
44 UNION MEMORIAL HOSPITAL | | | A. STATE MD.
B. COUNTY 2713 | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN BALTIMORE MD. | | |
| | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | E. STREET AND NUMBER 702 W. Lake AVE. | | |
| 5. SEX F | 6. RACE White | 7. MARRIED NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
05-09-76 | 9. AGE (In years last birthday) 93 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
HOME MAKER | | 11. BIRTHPLACE (State or foreign country)
OHIO | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
ROBERT J. MORRIS | | | |
| 14. MOTHER'S MAIDEN NAME
F. Roome, Anne | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MRS. NANCY L. BOYD | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
EXP. CAUSE | | 19. CAUSE OF DEATH
A. IMMEDIATE CAUSE
Respiratory arrest
B. DUE TO, OR AS A CONSEQUENCE OF:
C.H.F., Arteriosclerosis
C. DUE TO, OR AS A CONSEQUENCE OF:
became bedridden
D. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
FX. Ht RT. large blood obstruction due to valve | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
few minute
18 days
78 days
8 days | |
| 19A. DATE OF OPERATION
1-23-70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
FX. Ht RT. large blood obstruction | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
702 W. Lake AVE. BALTO. MD. | |
| 21D. TIME OF INJURY (Approx.)
1-22-70 6:30 PM | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Fell down from step | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-20-70 19 to 2-10 19 70 that (I) (we) last saw the deceased alive on 12 noon 2-10 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. Moazzenzadeh | | | | 23B. DATE SIGNED
2-10-70 | |
| 23C. PHYSICIAN'S NAME (Type)
A. Moazzenzadeh | | | | 23D. ADDRESS
Union Memorial Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/13/70 | | 24C. NAME OF CEMETERY or CREMATORY
Spring Grove | |
| 24D. LOCATION
Cincinnati, Ohio | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Mitchell Wiedefeld Home 6500 York Rd | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| N-620 70 1773 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1773 | |
|--|---------------------|---|--|--|--|--|-------------------------------|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) NORRIS, ELSIE | | | | 2. DATE AND HOUR OF DEATH
8 February 1970 6:50 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Good SAMARITAN HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
MARYLAND | | B. COUNTY
BALTIMORE | |
| C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
103 W. 39th St APT 1A 21210 | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MAY 20, 1889 | 9. AGE (In years last birthday)
80 | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Norfolk, Va. | | 12. CITIZEN OF WHAT COUNTRY?
UBA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
21814 2679 | | 17. INFORMANT ADDRESS
Mrs. Dorothy O'Malley-103 W. 39th | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Pneumonia, bronchial | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week | |
| | | | | (B) Pulmonary Fibrosis, Severe
DUE TO, OR AS A CONSEQUENCE OF:
3 years | | (C) Congestive Heart Failure
2 weeks | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Myocardial Infarctions | | old | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 27 1970 to February 8 1970 , that (I) (we) last saw the deceased alive on February 8 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
L. J. Buckels M.D. | | | | 23B. DATE SIGNED
February 8 1970 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/11/70 | | 24C. NAME OF CEMETERY or CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Balto. | |
| 25A. DATE RECD BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
E. Wiedefeld | | 25C. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home | | 25D. ADDRESS
6500 York Road. | |

| Year | 1990 | 1991 | 1992 | 1993 | 1994 |
|------|------|------|------|------|------|
|------|------|------|------|------|------|

1995 1996 1997

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1774 | |
|---|------------------------|---|---|---|---|
| <div style="display: flex; justify-content: space-between;"> M-300 70 1774 CERTIFICATE OF DEATH </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) GERALD J. MUTH | | 2. DATE AND HOUR OF DEATH
2/12/70 4:12 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE MD. B. COUNTY 2712 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Union Memorial Hosp | | | C. CITY OR TOWN
BALTO | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER
201 Church Wards Rd | | | | | |
| 5. SEX
M | 6. RACE
Can. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/16/98 | 9. AGE (In years lost birthday)
71 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
EXECUT (ATTY.) | | | 10B. KIND OF BUSINESS OR INDUSTRY
F.H.A. - GOV'T. | | 11. BIRTHPLACE (State or foreign country)
MD |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
JOHN C. MUTH | | | 14. MOTHER'S MAIDEN NAME
JULIA E. SMITH | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-14-1334 | 17. INFORMANT
MARY LEE C. MUTH | | ADDRESS
SAME |
| 18. CAUSE OF DEATH | | | | | |
| 4/10/9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute Myocardial Infarct | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic Heart Disease | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 2/4 19 70 to 2/12 19 70
that (I) (we) last saw the deceased alive on 2/12 19 70 and that (in my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
G. H. B. Ribbers | | | | 23B. DATE SIGNED
2/12/70 | |
| 23C. PHYSICIAN'S NAME (Type)
G. H. B. Ribbers | | | | 23D. ADDRESS
Union Memorial Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-14-70 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral | |
| 24D. LOCATION
Baltimore | | 24E. (City, town, or county) (State)
Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 13 1970 | | 25B. NAME OF REGISTRAR
John E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co., Balto., Md. | |

(1)
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

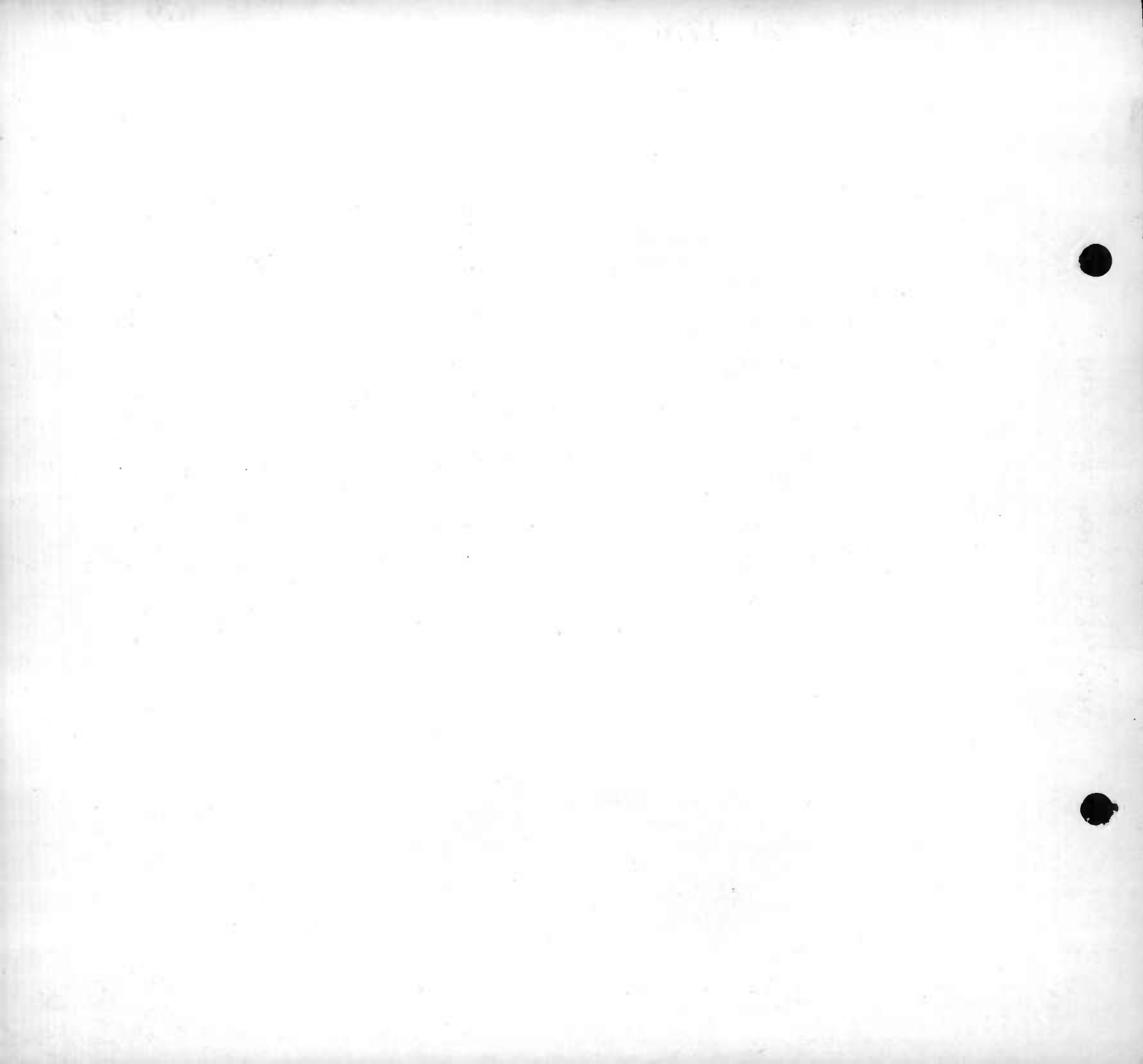
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1775</u> | |
|--|---------------------|---|---|---|---|
| BIRTH NO. <u>R-240 70 1775</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>Eleanor Patterson Russell</u> | | | 2. DATE AND HOUR OF DEATH
<u>Feb. 13, 1970</u> <u>6:08 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>90 Longgreen Nursing Home</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>2714</u>
C. CITY OR TOWN <u>Baltimore</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> * NO <input type="checkbox"/>
E. STREET AND NUMBER <u>4 Upland Road</u> | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8-21-1888</u> | 9. AGE (In years last birthday)
<u>81</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | 11. BIRTHPLACE (State or foreign country)
<u>Wheeling W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> |
| 13. FATHER'S NAME
<u>Andrew Patterson</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Dorothy Hollingsworth</u> | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
<u>Mrs. W. D. Buttner 413 Hawthorne Rd.</u> | | |
| 18. <u>412.4 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Acute Pulmonary Edema</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<u>as above</u>
(C) <u>Thrombophlebitis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>13 Feb 1970</u> that (I) (we) last saw the deceased alive on <u>10 Feb 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Dr. Wm G. Helfrich</u> | | | | 23B. DATE SIGNED
<u>2/13/70</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Dr. Wm G. Helfrich</u> | | | | 23D. ADDRESS
<u>5006 Roland Ave.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2-16-70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Greenmount Cemetery</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 13 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Jenkins</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|-------------------------|---|---|--|---|
| R-000 70 1776 | | 70 1776 | | BALTIMORE CITY HEALTH DEPARTMENT | |
| BIRTH NO. | | 70 1776 | | BALTIMORE CITY HEALTH DEPARTMENT | |
| 1. NAME OF DECEASED
(Type or Print) <u>Mary Roy</u> | | | 2. DATE AND HOUR OF DEATH
<u>2-9-70</u> <u>8:20</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>1503</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Hof Lutheran Hospital</u> | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<u>3118 Westwood Ave.</u> | | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 12, 1918</u> | 9. AGE (In years last birthday)
<u>51</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>DOMESTIC</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Richmond CO. VA</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Tom Roy</u> | | 14. MOTHER'S MAIDEN NAME
<u>ETTA CORBIN</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>219-30-8499</u> | | 17. INFORMANT ADDRESS
<u>SAMUEL W. CORBIN 1128 LAURENCE ST.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.)
<u>Respiratory Failure</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>7 days</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Acute pulmonary edema. 22 hrs. after adm.</u> | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>after adm.</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Abdominal mass ? Ovarian neoplasm</u> | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No.</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>—</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
<u>—</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
<u>—</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>—</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/8/1970</u> to <u>2/9/1970</u> , that (I) (we) last saw the deceased alive on <u>2/9/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Subash C. Ahuja, MD</u> | | | | 23B. DATE SIGNED
<u>2/9/70</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>SURASH C AHUJA M.D.</u> | | | | 23D. ADDRESS
<u>Lutheran Hosp.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>2/13/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>MT CALVARY CEM.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>CEGAR Hill Balt. Md.</u> | | 24E. DATE REC'D BY HEALTH DEPT.
<u>FEB 16 1970</u> | | 24F. NAME OF REGISTRAR
<u>Robert F. Jones</u> | |
| 24G. FUNERAL DIRECTOR
<u>DONALD E. GLOVER</u> | | 24H. ADDRESS
<u>170 W. PATTERSON ST.</u> | | 24I. DATE
<u>NOV</u> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1777

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
THEODORE NEWKIRK | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
February 10, 1970 9:35 P. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
CHURCH HOME AND HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
February 10, 1970 9:35 P. | |
| 6. SEX
Male | | 7. RACE
Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 1002 | |
| 9. DATE OF BIRTH
NOV 7, 1905 | | 10. AGE (In years last birthday) 64
If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
MATTIE NEWKIRK | | ADDRESS
709 N. CENTRAL AVE | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Cardiovascular Disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
2/11/70 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2/16/70 | |
| 24C. NAME OF CEMETERY or CREMATORY
MT CALvary CEM | | 24D. LOCATION (City, town, or county) (State)
Cedar Hill BALTO md | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Bailey, M.D. | |
| 25C. FUNERAL DIRECTOR
Donald E. Glover | | ADDRESS
1701 N. PATTERSON ST | |

ACADEMIC BOND

THE UNIVERSITY OF TEXAS
AT AUSTIN

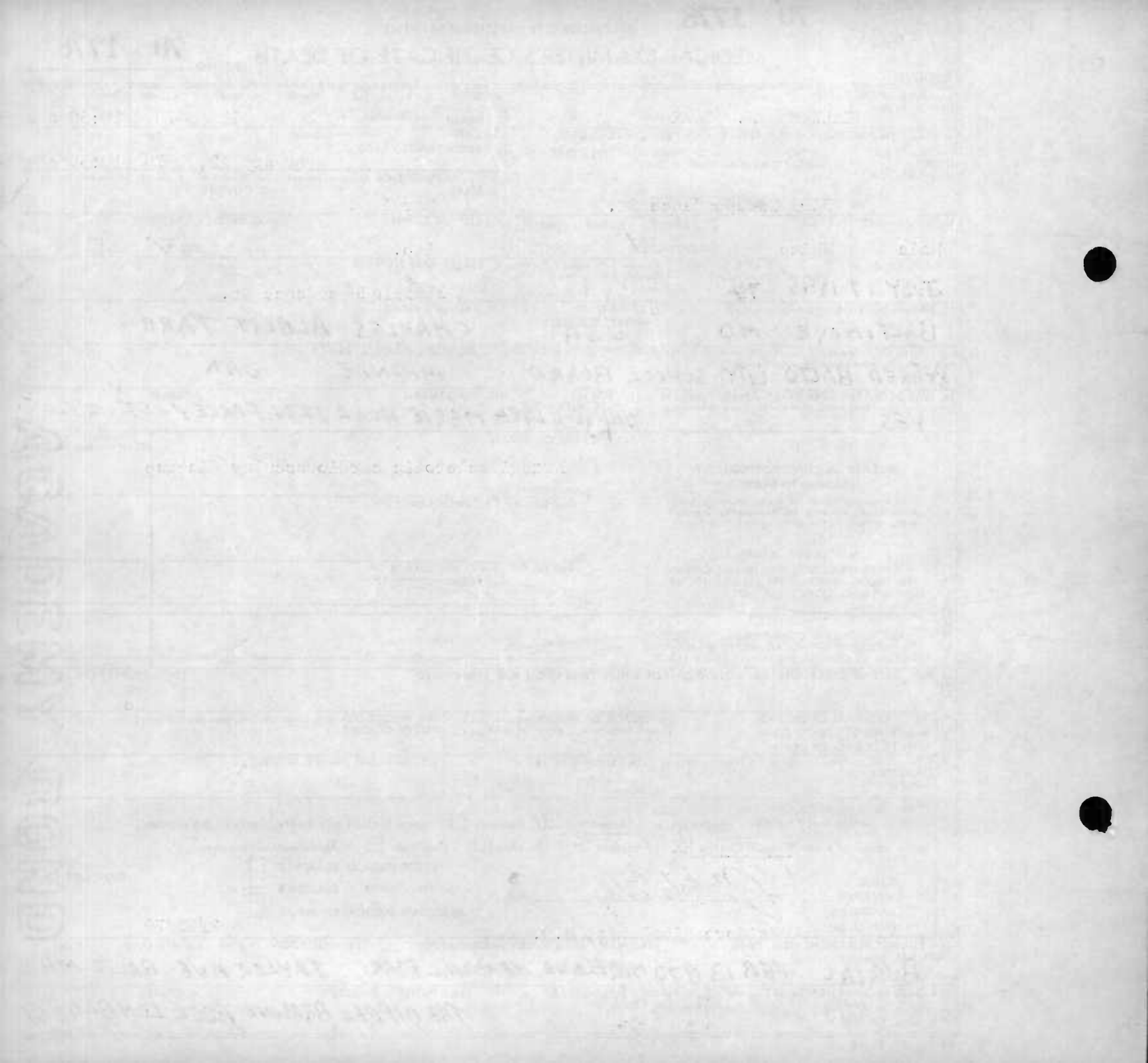
STATE OF TEXAS
COUNTY OF _____

BEFORE ME, the undersigned authority, on this _____ day of _____, 20____, personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 20____.

Notary Public in and for the State of Texas

| T-600 | | 70 1778 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | 70 1778 | | | |
|---|--|----------------------------------|--|---|--|--|--|--|--|--|--|
| BIRTH NO. | | | | REG. NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE OF DEATH | | Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year | | Hour | |
| WILLIAM J. TARR | | | | 2 | | 12 | | 70 | | 10:50 a. M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | 3. DATE PRONOUNCED DEAD | | Month Day Year | | Hour | | | |
| 00 3105 Independence St. | | | | February 12, 1970 | | 10:50 a. M. | | | | | |
| 6. SEX | | | | 7. RACE | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| Male | | White | | | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| JULY 17 1895 | | 74 | | BALTIMORE MO | | USA | | CHARLES ALBERT TARR | | MINNIE JNK | |
| 15. MOTHER'S MAIDEN NAME | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT | | ADDRESS | |
| | | | | YES | | 214-10-4448 | | MARIE HOWE | | 1234 FARLEY ST 21205 | |
| 19. CAUSE OF DEATH | | | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | Arteriosclerotic cardiovascular disease | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | |
| ANTECEDENT CAUSES | | | | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 20A. DATE OF OPERATION | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) | | | |
| | | | | | | | | No | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (APPROX.) | | | | 22E. INJURY OCCURRED | | | | 22F. HOW DID INJURY OCCUR? | | | |
| | | | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER | | | | | | | |
| Isidore Mihalakis M.D. | | | | ASSOCIATE MEDICAL EXAMINER | | | | 2/13/70 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| BURIAL | | | | FEB 13 1970 | | MORELAND MEMORIAL PARK | | TAYLOR AVE BALTO MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| FEB 16 1970 | | | | J. E. [Signature] | | | | THE DIPPEC BROS INC 1800 E LOMBARD ST | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|---|-------------------------------------|---|-----------------------------|--|--|
| BIRTH NO. D-366 | | 70 1779 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1779 | |
| 1. NAME OF DECEASED
(Type or Print) NELSON DOTTERER | | | | 2. DATE AND HOUR OF DEATH
2-10-70 5:30 PM. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
44 UNION MEMORIAL HOSPITAL
33RD + CALVERT ST.
BALTIMORE MARYLAND 21218 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)
A. STATE BALTIMORE B. COUNTY MARYLAND
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 944 N. HILL ROAD | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
06-10-08 | 9. AGE (In years last birthday)
61 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SUPT. | | 10B. KIND OF BUSINESS OR INDUSTRY
BUREAU OF HIGHWAYS | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
NELSON C. DOTTERER | | | | 14. MOTHER'S MAIDEN NAME
KATHERINE WAITMORE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-10-3376 | | 17. INFORMANT ADDRESS
DORTHY E DOTTERER SAME | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
562.1 I CHRONIC obstructive AIRWAY DISEASE
PERFORATED SIGMOID DIVERTICULITIS
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: w/ PERITONITIS
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
02-05-70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
PERFORATED DIVERTICULITIS of SIGMOID COLON | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 02-03 1970 to 02-10 1970 that (I) (we) last saw the deceased alive on 02-10 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Evelyn P. Navarro | | | | 23B. DATE SIGNED
02-10-70 | | 23C. PHYSICIAN'S NAME (Type) EVELYN P NAVARRO MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
2-13-70 | | 24C. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery, Pikesville, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | | | 25B. NAME OF REGISTRAR
BURGER | | 25C. FUNERAL DIRECTOR
BURGER Funeral Home, Balto, Md. | |

UNION MEMORIAL HOSPITAL -
FIVE + GARRETT ST.
Baltimore Maryland 21218

M W X
04-10-68 12

Surgeon General's Office
Baltimore, Maryland

NEEDON & BUTTER
PATENTERS

Patented by the
United States Patent
Office

U.S. PATENT OFFICE
WASHINGTON, D.C. 20540

02-10-68

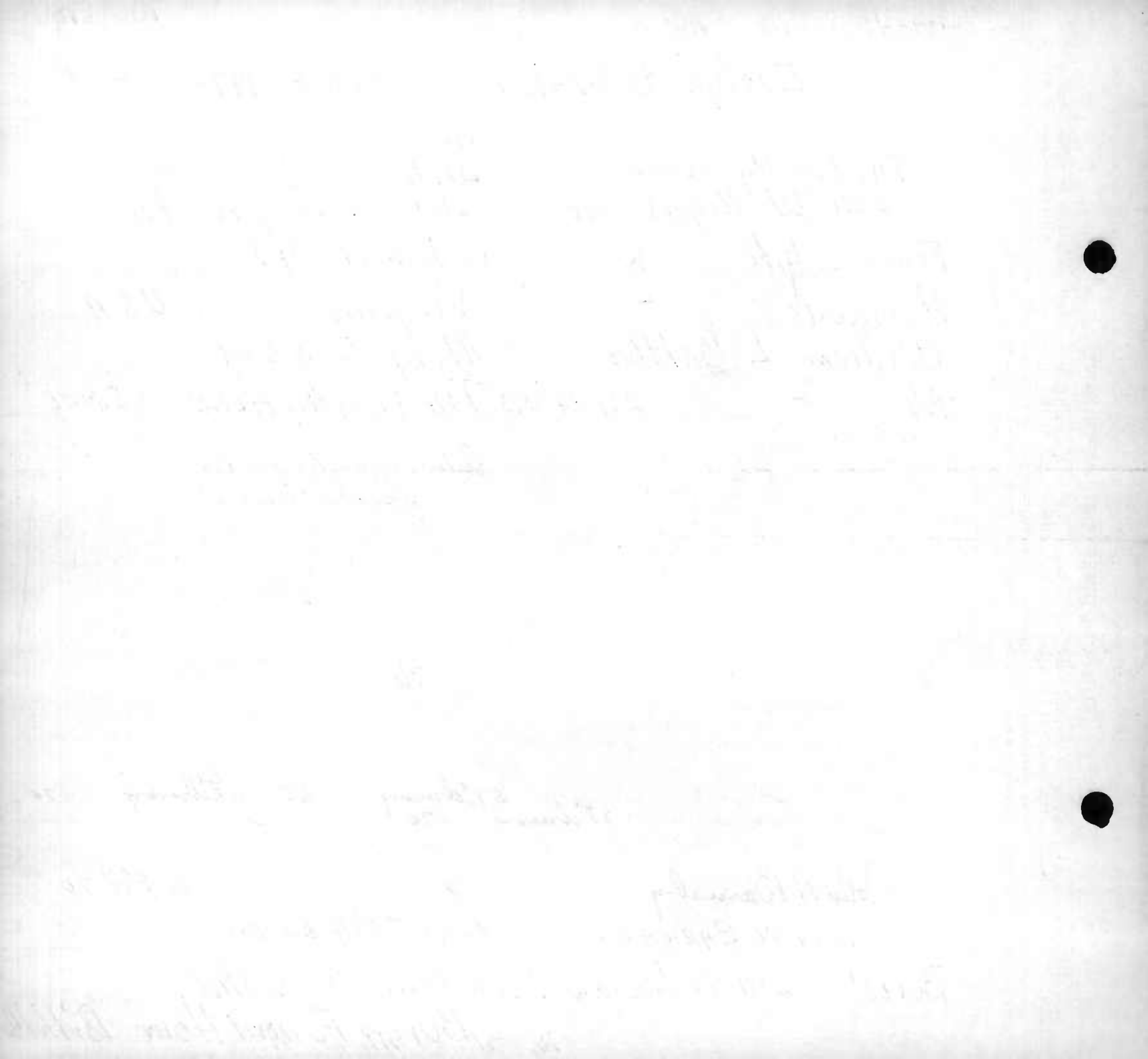
02-10-68

EVERETT P. NAVARRO
FIVE + GARRETT ST.
Baltimore, Maryland

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1780 | |
| W-420 70 1780 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Evelyn B Walsh | | 2. DATE AND HOUR OF DEATH
Feb 8 1970 4 P | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md B. COUNTY Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
The Wesley Home
90 2211 W Rogers Ave | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 15 June 77 9. AGE (In years last birthday) 92 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 10B. KIND OF BUSINESS OR INDUSTRY - | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William L Balthus | | 14. MOTHER'S MAIDEN NAME Mary E Shad | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 238 74 3813 | |
| 17. INFORMANT The Wesley Home | | ADDRESS same | |
| 18. 413.41 CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Anterograde arterio-sclerotic cardiovascular disease | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5 February 1965 to 8 February 1970 , that (I) (we) last saw the deceased alive on 8 February 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE John W Barnaby | | 23B. DATE SIGNED 10 Feb 70 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN W BARNABY | | 23D. ADDRESS 1652 E Belvidere Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-11-70 | |
| 24C. NAME of CEMETERY or CREMATORY London Park Cem | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 16 1970 | | 25B. NAME OF REGISTRAR Burgess Funeral Home | |
| 25C. FUNERAL DIRECTOR Burgess Funeral Home | | ADDRESS Baltimore Md | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| G-625 | | 70 1781 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1781 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) NANCY GIRKINS | | | |
| 2. DATE AND HOUR OF DEATH
2/11/1970 11 P.M. | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
BALTIMORE CITY HOSPITAL | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Baltimore Co. C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
31 4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 5. SEX Female 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH 6-13-10 9. AGE (In years last birthday) 59 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES-CLERK | | | | 10B. KIND OF BUSINESS OR INDUSTRY DEPT. STORE | | | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME PATRICK HAGAN | | | | 14. MOTHER'S MAIDEN NAME MARIE DINGUS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES | | | | 16. SOCIAL SECURITY NO. 218-34-0156 | | | |
| 17. INFORMANT 4940 Eastern Avenue | | | | ADDRESS BCH Records - Baltimore, Maryland 21221 | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 m
2 wk | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 1-29 19 70 to 2-11 19 70 , that (H) (we) last saw the deceased alive on 2-11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John R. Brechtel, M.D. | | | | 23B. DATE SIGNED 2-12-70 | | | |
| 23C. PHYSICIAN'S NAME (Type) John R. Brechtel, M.D. | | | | 23D. ADDRESS 4940 Eastern Avenue | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 2/16/70 | | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN | |
| 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | | | 25A. DATE REC'D BY HEALTH DEPT. FEB 16 1970 | | 25B. NAME OF REGISTRAR John R. Brechtel, M.D. | |
| 25C. FUNERAL DIRECTOR J. J. CONNELLY SONS | | | | 25D. ADDRESS 300 N. E. MACE | | | |

10-1-01 18-1-01

10-1-01

10-1-01 18-1-01

10-1-01

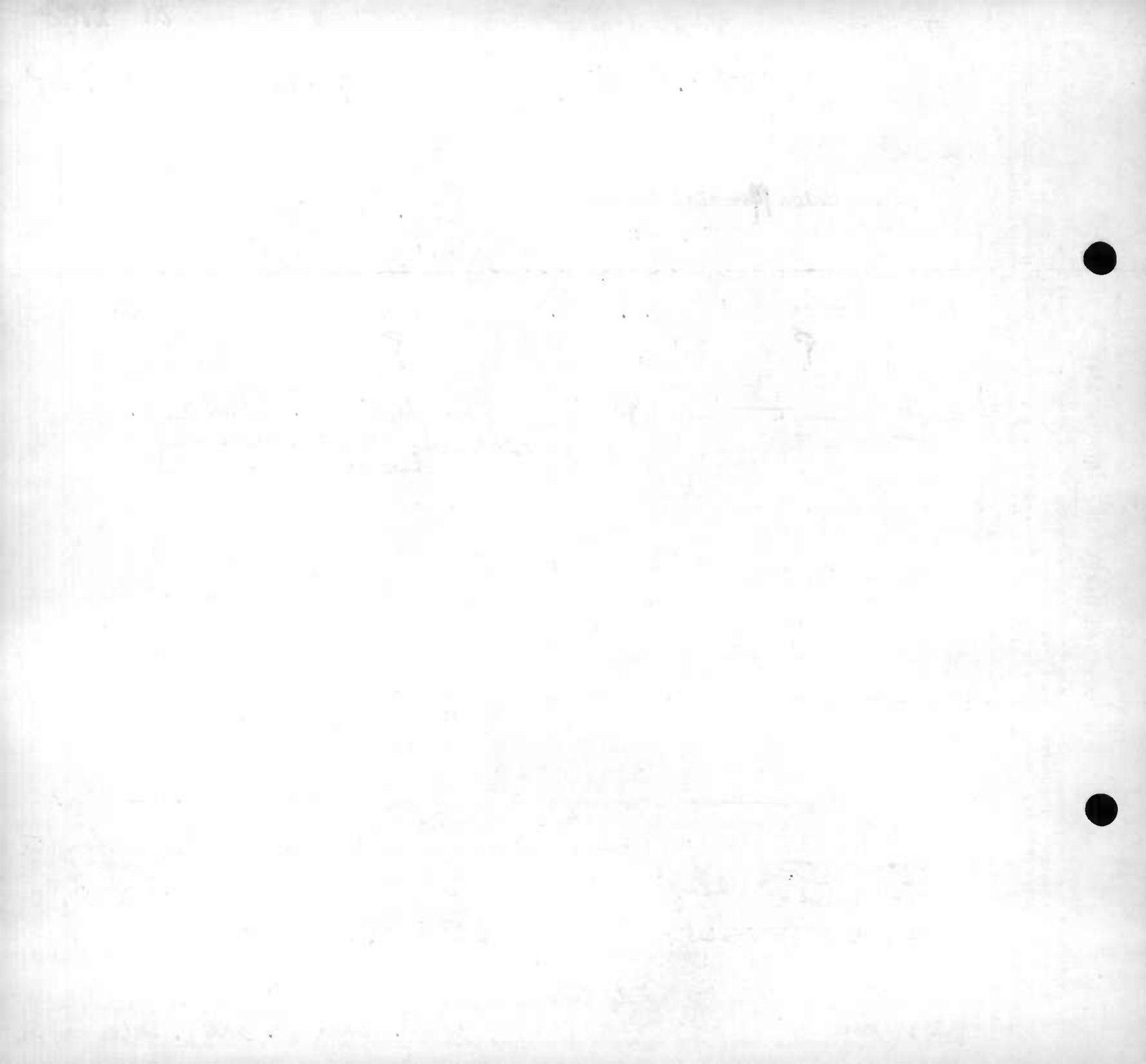
10-1-01 18-1-01

10-1-01

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1782</u> | |
|---|---------------------|--|------------------------------------|--|---|
| E-245 R 1702 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) <u>Albert J. Eklund</u> | |
| 2. DATE AND HOUR OF DEATH
<u>2/2/70</u> <u>1:30 P.</u> | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

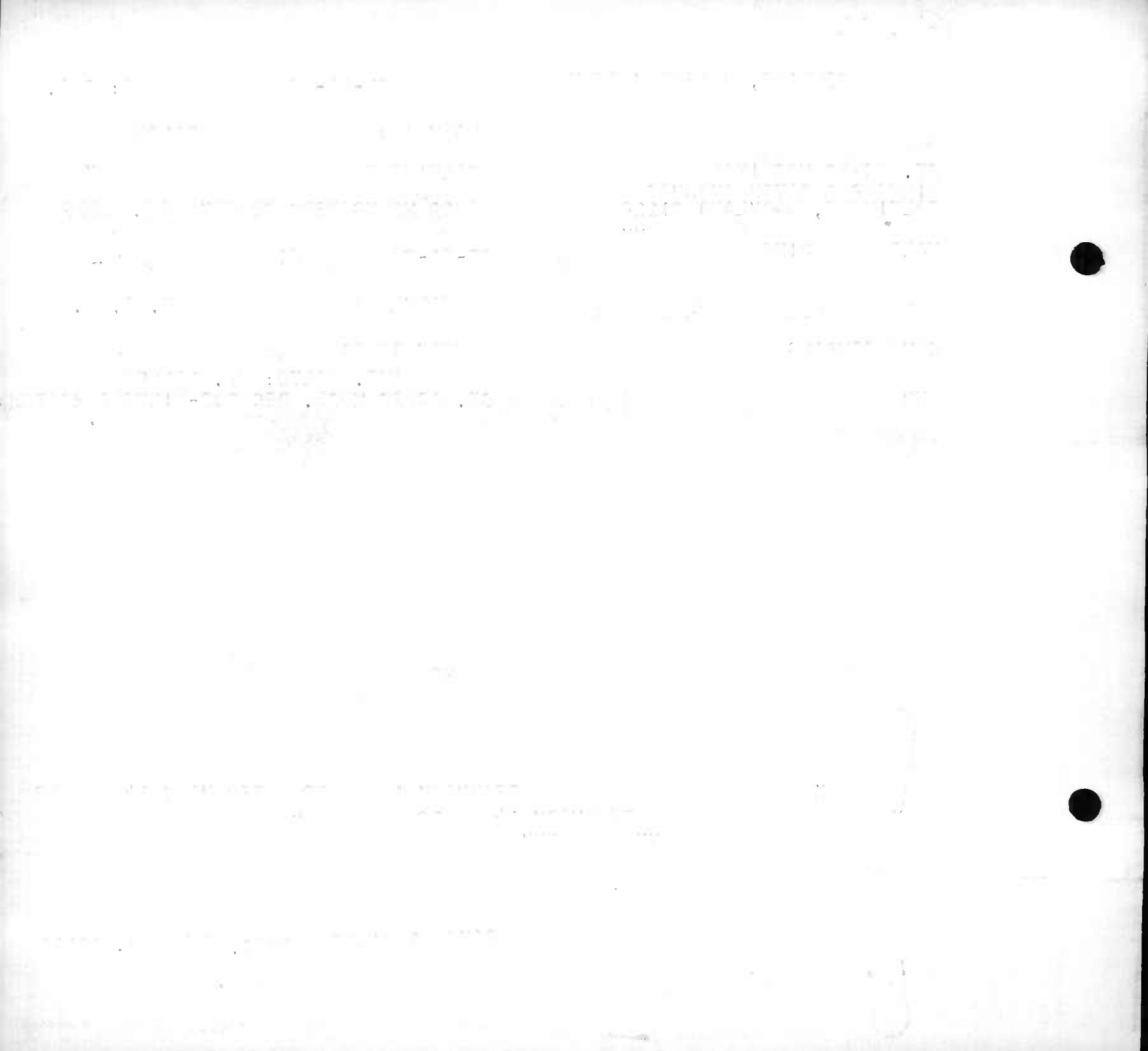
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>44 Union Memorial Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>1203</u>
C. CITY OR TOWN <u>Baltimore</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>437 E. 25th Street</u> | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1/26/85</u> | 9. AGE (In years last birthday)
<u>85</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Letter Carrier</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Govt.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>?</u> | | 14. MOTHER'S MAIDEN NAME
<u>?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>46</u> | | 17. INFORMANT
<u>Mrs. Elizabeth A. Eklund</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>412.41</u>
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
<u>Arteriosclerosis Cordis Vascular</u>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>2/12</u> 1970, that (I) (we) last saw the deceased alive on <u>2/3</u> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <u>DOA - Union Memorial Hospital</u> | | | |
| 23A. SIGNATURE
<u>Thomas L. Worsley</u> | | 23B. DATE SIGNED
<u>2/13/70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>THOMAS L. WORSLEY</u> | |
| 23D. ADDRESS
<u>6565 YORK Rd BALTO Md 21212</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/16/70</u> | |
| 24C. NAME OF CEMETERY or CREMATORY
<u>H. H. Redeemer Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 16 1970</u> | |
| 25B. NAME OF REGISTRAR
<u>John A. Moran, Inc.</u> | | 25C. FUNERAL DIRECTOR
<u>3000 E. Baltimore St</u> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

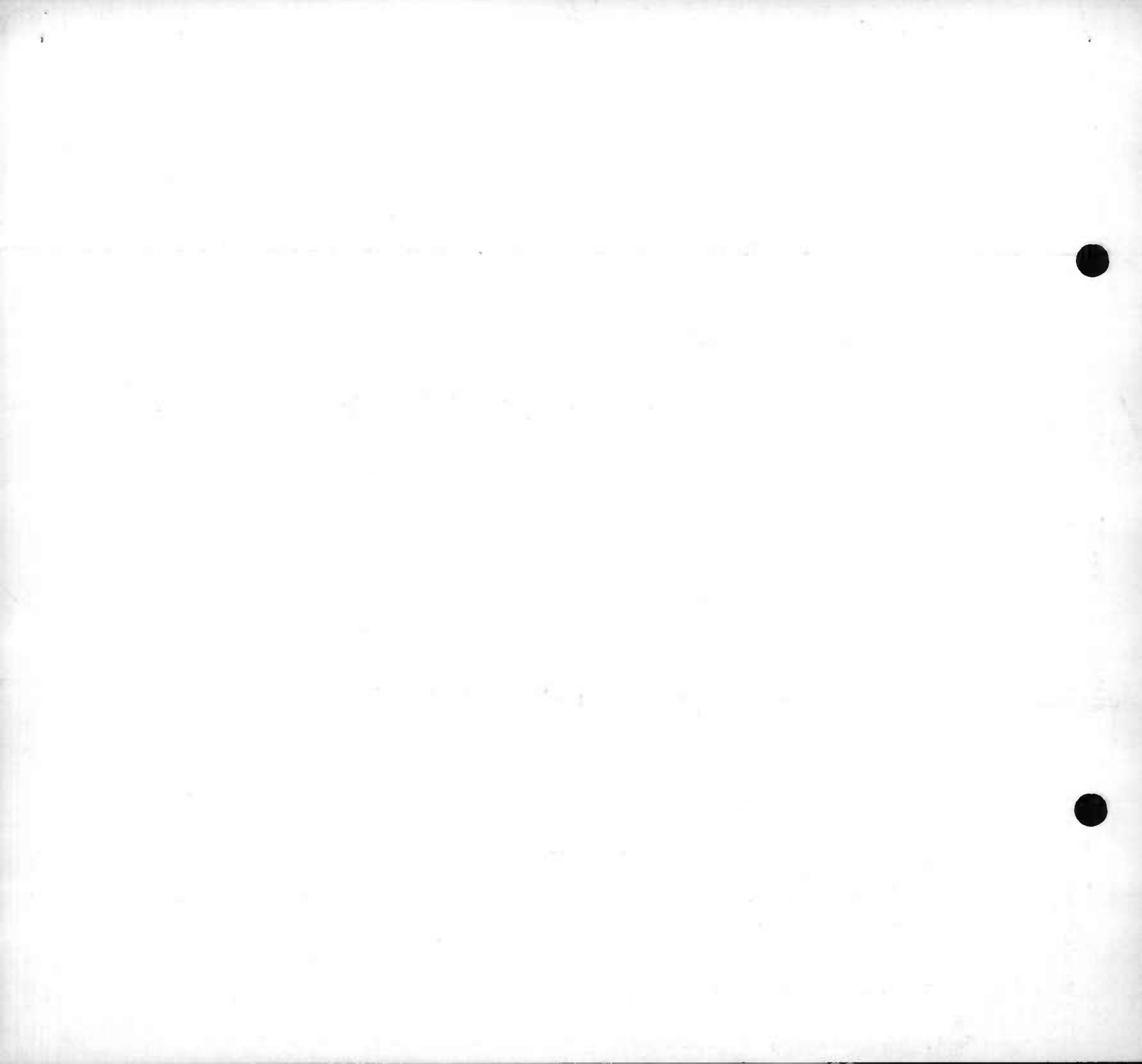
| | | | | | |
|---|-------------------------|---|--|--|---|
| <div style="display: flex; justify-content: space-between;"> G-652 70 1783 </div> | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. 70 1783 | |
| 1. NAME OF DECEASED
(Type or Print) GEHRING, ROBERT JOSEPH | | | 2. DATE AND HOUR OF DEATH
02-14-70 6:05 A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND 21207
B. COUNTY 53-00 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST. AGNES HOSPITAL
WILKENS & CATON AVENUES
BALTIMORE, MARYLAND 21229 | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | E. STREET AND NUMBER
6023 MONTGOMERY STREET AVE. 21207 | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
07-01-08 | 9. AGE (In years last birthday)
61 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Carpenter | | 10B. KIND OF BUSINESS OR INDUSTRY
Acme Stores | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY
U. S. A. | | 13. FATHER'S NAME
JOHN GEHRING | | | |
| 14. MOTHER'S MAIDEN NAME
MARY DOWER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | |
| 16. SOCIAL SECURITY NO.
217-16-0948 | | 17. INFORMANT AVE. BALTO; MD. 21229
ST. AGNES HOSP. RECORDS-WILKENS & CATON | | | |
| 18. 444.21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Myocardial Infarction
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | CAUSE OF DEATH
Myocardial Infarction
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Heart Failure
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 1 19 70 to FEBRUARY 14 19 70 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEBRUARY 14 19 70 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>J. Longme</i> | | | 23B. DATE SIGNED
2-14-70 | | |
| 23C. PHYSICIAN'S NAME (Type)
JESABA MURRAY M.D. | | | 23D. ADDRESS
CATON & WILKENS AVES BALTO MD, 21229 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/18/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
Miss. Wilkins Funeral Home - Wilkins & Silmar | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

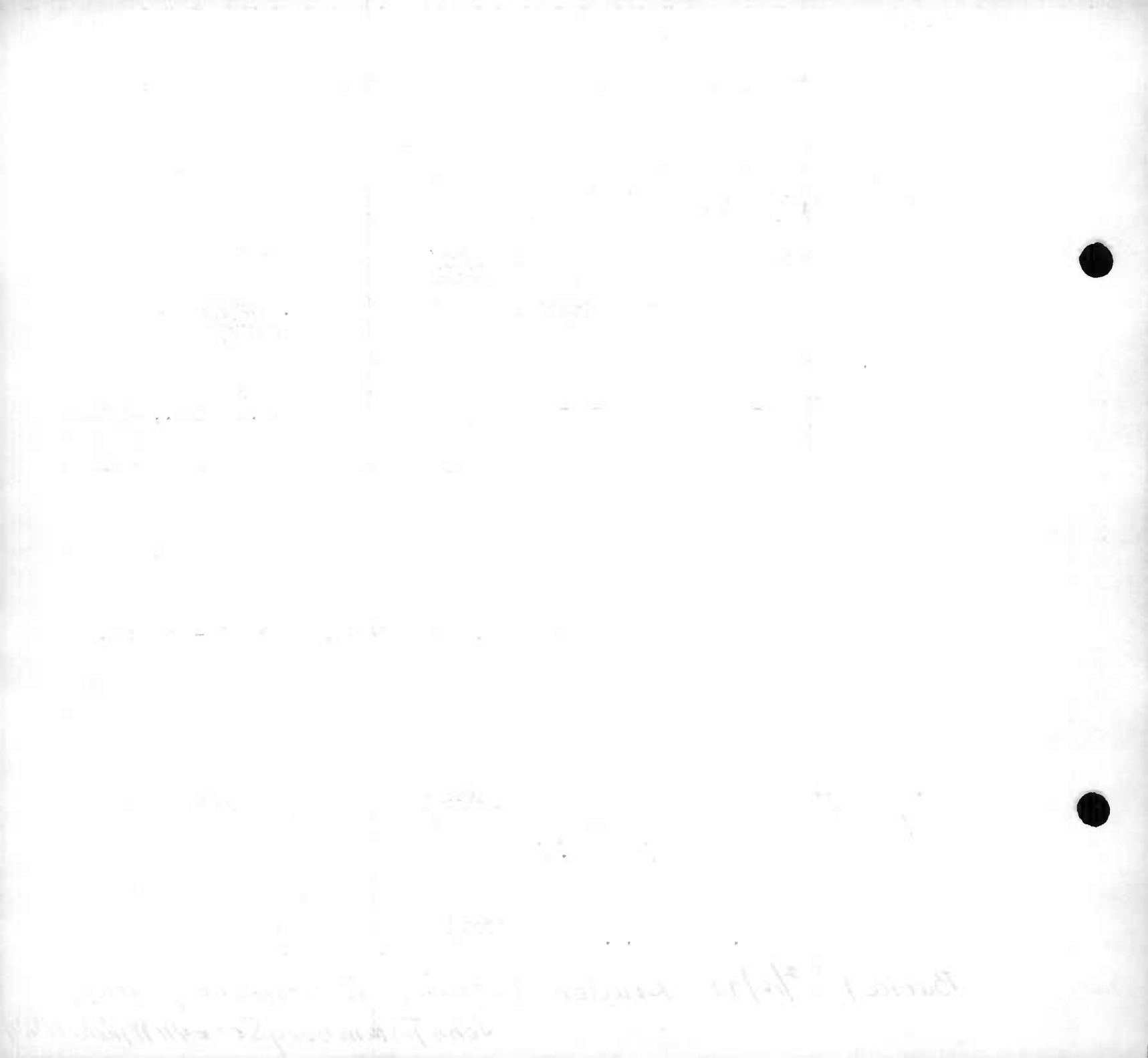
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1784 | |
|---|---|---|---|---|---|
| H-436 | | 70 1784 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Elmer Holder | | 2. DATE AND HOUR OF DEATH
2/9/70 10:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Univ Hospital - Balto Md
38 | | A. STATE
Maryland | | B. COUNTY
2553 | |
| | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
1931 Hollins Ferry Road | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/28/13 | 9. AGE (In years last birthday)
56 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Survill | | 10B. KIND OF BUSINESS OR INDUSTRY
? | | 11. BIRTHPLACE (State or foreign country)
North Carolina? | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Lennie Holder | | 14. MOTHER'S MAIDEN NAME
? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
246-10-0794 | | 17. INFORMANT
Leona Holder 7M Wolff St | |
| 18. 682.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Multiple Respiratory + Circulatory arrest
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) Emphysema & Bronchopneumonia & lobes pneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
14 hrs | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/8 19 70 to 2/9 19 70 that (I) (we) last saw the deceased alive on 2/8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Charles S. Samorodin | | 23B. DATE SIGNED
2/9 | | 23C. PHYSICIAN'S NAME (Type)
Charles S. Samorodin | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/13-70 | | 24C. NAME of CEMETERY or CREMATORY
Mt. Olivet | |
| 24D. LOCATION
Baltimore Md | | 24E. LOCATION
Md. | | 24F. LOCATION
Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
R. E. J. R. R. R. | | 25C. FUNERAL DIRECTOR
Frank H. Kelly 814 N 36 St | |



FUNERAL DIRECTOR: IMPORTANT

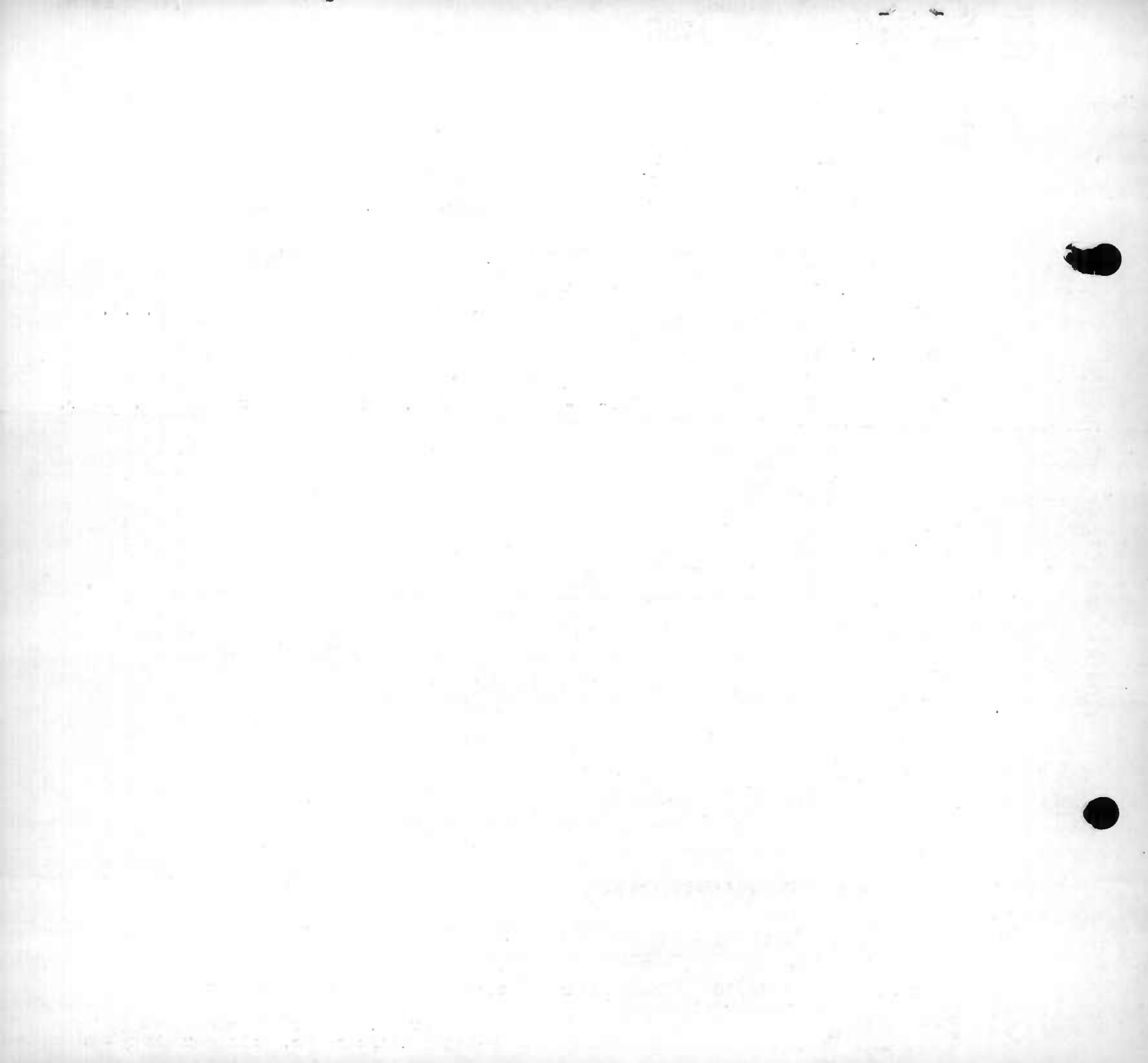
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>70 1785</u> | |
| L-260 <u>70 1785</u> | | 70 1785 | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>LEISHER, William Stephens</u> | | 2/11/70 8:25 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>23 Veterans Administration Hospital</u>
<u>3900 Loch Raven Boulevard</u>
<u>Baltimore, Md 21218</u> | | A. STATE <u>Maryland</u>
B. COUNTY <u>2788</u> | |
| | | C. CITY OR TOWN | D. INSIDE CITY LIMITS? |
| | | <u>Baltimore</u> | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
<u>5256 Nelson Avenue</u> | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH |
| <u>Male</u> | <u>White</u> | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | <u>6/29/08</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) |
| <u>Attendant</u> | | <u>Service Station</u> | <u>61</u> |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Wilksburg, Pa.</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| <u>Samuel E. Leisher</u> | | <u>Ida Stevens</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| <u>YES</u> <u>4/6/44 - 3/4/46</u> | | <u>128-05-7190</u> | |
| 17. INFORMANT | | ADDRESS | |
| <u>VA Hospital Records</u> | | <u>3900 Loch Raven Blvd., Balto., Md 21218</u> | |
| 18. CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Presumed Cancer of pancreas</u> | | | <u>8 months</u> |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | <u>Pulmonary, Tuberculosis, Moderately-advanced, active</u> |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| <u>0</u> | | <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| <input type="checkbox"/> | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| | | | |
| 22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>October 17th</u> 19 <u>69</u> to <u>February 11th</u> 19 <u>70</u> that <u>(X)</u> (we) last saw the deceased alive on <u>February 11th</u> 19 <u>70</u> and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | |
| <u>David N. Marine</u> | | <u>2/13/70</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| <u>DAVID N. MARINE M.D.</u> | | <u>3900 Loch Raven Boulevard</u>
<u>Baltimore, Maryland 21218</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>2/16/70</u> | <u>Loudon National</u> | <u>Baltimore, Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | |
| <u>FEB 16 1970</u> | <u>Robert E. Taylor, M.D.</u> | <u>John T. Stansbury Sr. 6411 Windsor Mill</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1786 |
|---|-----------|--|---------------------------------------|--|
| 70 1786 | | | | 70 1786 |
| D-320 | | | | REG. NO. |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH |
| | | WILFORD G. DIETZ | | FEB 11, 1970 11:00 P.M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | |
| LUTHERAN HOSP. OF MD. | | Maryland | | |
| C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | |
| Baltimore | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER | | 1009 Parksley Ave. | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11-3-94 | 75 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| Clerk | | BALTO Gas + Elec. | | Maryland |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | |
| John H. Dietz | | Anna Aickley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| YES WW1 | | 212-05-5478 | | Anna K. Dietz 1009 Parksley Ave. Balto. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | PNEUMONIA. | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | TUMOR OF THE BODY OF TS | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 11-25-69 | | TUMOR OF BODY OF TS | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-21-1969 to FEB 11 1970, that (I) (we) last saw the deceased alive on FEB 11, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | |
| Sunan Vongkasensiri | | Feb 11, 70 | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | |
| SUNAN VONGKASENSIRI, MD. | | LUTHERAN HOSP. OF MD. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
| Burial | 2/14/70 | Loudon Park Cemetery | Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS |
| FEB 16 1970 | | Robert E. Fisher, M.D. | | Howard H. Hubbard Funeral Home
4107 Wilkens Ave. Baltimore, Maryland |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| C-650 70 1787 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1787 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) CHERNEY, FRIEDA S. | | 2. DATE AND HOUR OF DEATH
February 11, 1970 5:30 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland 8. COUNTY Baltimore 21207 53-00 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
GOOD SAMARITAN HOSPITAL
5601 Loch Raven Blvd.
Baltimore, Maryland 21212 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Female 6. RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-28-1908 9. AGE (In years last birthday) 71 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
milking | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New Jersey 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME
Rueben Nobleman | | 14. MOTHER'S MAIDEN NAME
MacKowski | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216326544D | | 17. INFORMANT Robert Schwab ADDRESS 3411 Medfield Pk. | |
| 18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Respiratory and Cardiac arrest | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Respiratory and Cardiac arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
few minutes | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (B) disseminated undifferentiated carcinoma | | (C) undifferentiated carcinoma | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from Nov 20 1969 to Feb 11 1970 , that (we) last saw the deceased alive on Feb 11 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
H Semerdjian | | | | 23B. DATE SIGNED
2/11/70 | |
| 23C. PHYSICIAN'S NAME (Type)
Grant S. Semerdjian M.D. | | 23D. ADDRESS
Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/13/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Balto Hebrew | |
| 24D. LOCATION (City, town, or county)
Balto | | 24E. STATE
Md | | 24F. ZIP CODE
21207 | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Sylvan Lewis & Son ADDRESS 9610 Reisterstown Rd | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. [REDACTED] | |
|--|------------------|--|----------------------------|--|--|
| J-525 | | 70 1788 | | 70 1788 | |
| BIRTH NO. | | 70 1788 | | 70 1788 | |
| 1. NAME OF DECEASED
(Type or Print) | | EMMA E. JOHNSON | | 2. DATE AND HOUR OF DEATH
2/11/70 11 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE
Md. | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Baltimore city Hosp.
4940 Eastern Avenue
Baltimore, Maryland 21224 | | B. COUNTY
Baltimore | | C. CITY OR TOWN
Baltimore | |
| | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
218 S. Clinton St. | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-2-92 | 9. AGE (In years last birthday)
77 1/2 | 10. If Under 1 Year: Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
John Johnson | | 14. MOTHER'S MAIDEN NAME
Anna Svenson | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
[REDACTED]-05-7496 | | 17. INFORMANT
ECH: RECORDS Baltimore, Maryland 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
43291
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 19. CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
possible pulmonary emboli
Thrombosis of anterior spinal artery resulting to the quadriplegia
(B) DUE TO, OR AS A CONSEQUENCE OF:
generalized edema
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
218 S. Clinton | |
| 21D. TIME OF INJURY (APPROX.)
Jan 24, 1970 | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Fell at home | |
| 22. I certify that (this hospital) attended the deceased from 1-24-1970 to 2-11-1970 that (we) last saw the deceased alive on 2-11-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Mehdi Sarkarati M.D. | | 23B. DATE SIGNED
2/11/70 | | 23C. PHYSICIAN'S NAME (Type)
Mehdi Sarkarati M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/14/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt. Carmel Cemetery | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 24F. FUNERAL DIRECTOR
John A. Moran, Inc. | |
| 24G. ADDRESS
3000 E. Baltimore St. | | 24H. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 24I. VS 150-REV. 1/1/68 | |

[REDACTED]

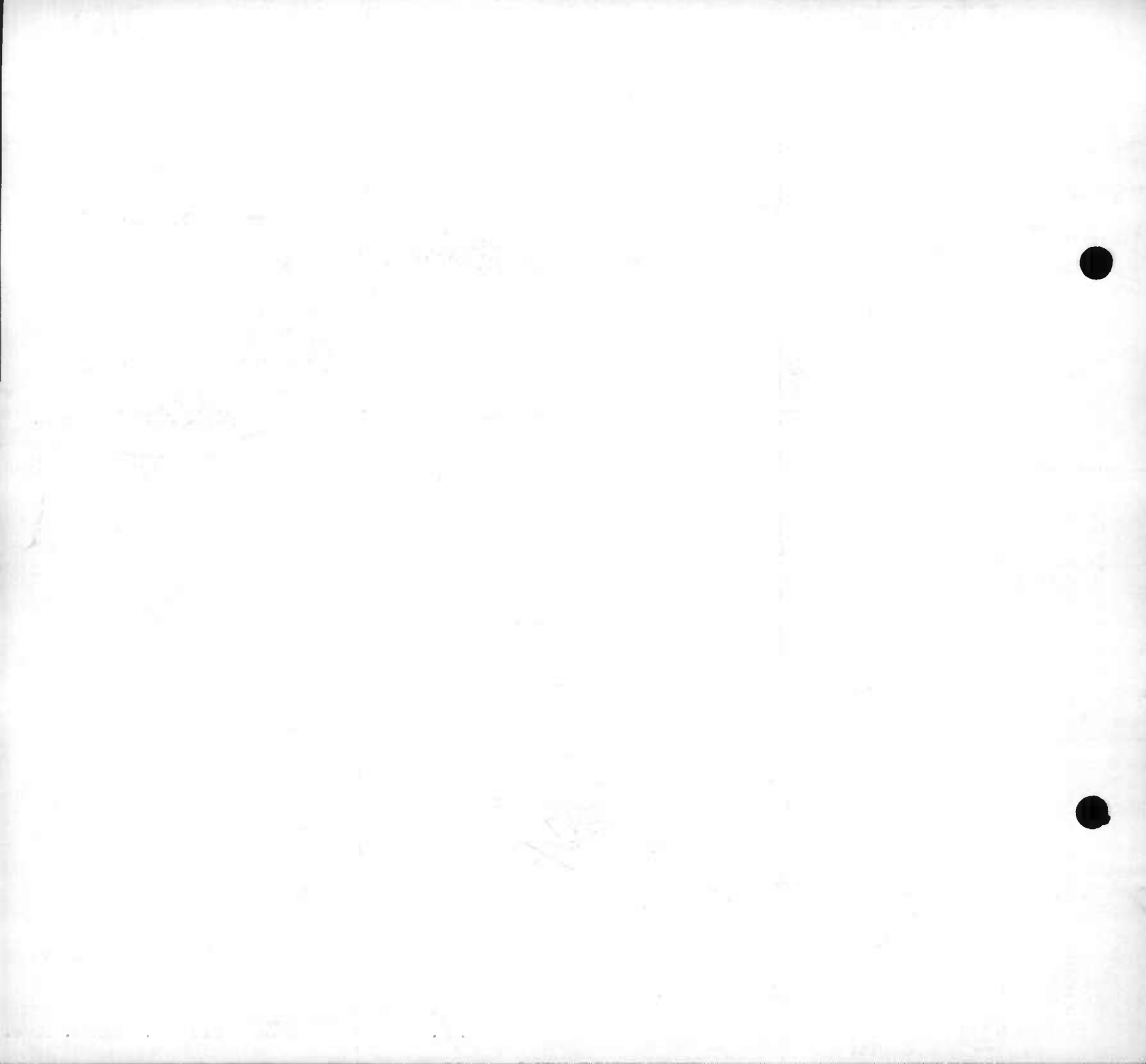


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1789 | |
|---|-----------------------------|---|--------------------------------------|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. D-136 70 1789 | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Anna C. DiPietro</u> | | 2. DATE AND HOUR OF DEATH
<u>2-9-70</u> <u>3:00</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>38 UNIVERSITY Hospital</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>302</u> | | | |
| | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>239 S. Exeter Street 21202</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>CAUCASIAN</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9/21/1886</u> | 9. AGE (In years last birthday)
<u>83</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOMEMAKER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>ITALY</u>
<u>XXXXXXXXXXXX</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>UNKNOWN</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>XXXXXXXXXXXX DIGABRIELE</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>215-01-6343</u> | | 17. INFORMANT
<u>ALFRED DIPIETRO</u>
<u>2 Sugar Bury Court Reisterstown, Md.</u> | | | |
| 18. CAUSE OF DEATH
<u>410.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarct</u>
(B) <u>ASCVD</u>
(C) <u>—</u> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>—</u> | | | | | |
| 19A. DATE OF OPERATION
<u>None</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>—</u> | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>—</u> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)
<u>—</u> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
<u>—</u> | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
<u>—</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<u>—</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-8</u> 19 <u>70</u> to <u>2-9</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2-9</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Charles E. DeFelic</u> | | 23B. DATE SIGNED
<u>2-9-70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>CHARLES E. DeFelic</u> | |
| 23D. ADDRESS
<u>UNIVERSITY Hospital, MD</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | |
| 24B. DATE
<u>2/13/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Parkwood Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 16 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Sabin</u> | | 25C. FUNERAL DIRECTOR
<u>J. E. Lowell Lemmon</u> | |
| | | | | ADDRESS
<u>4611 Pk. Hghts. Ave.</u> | |



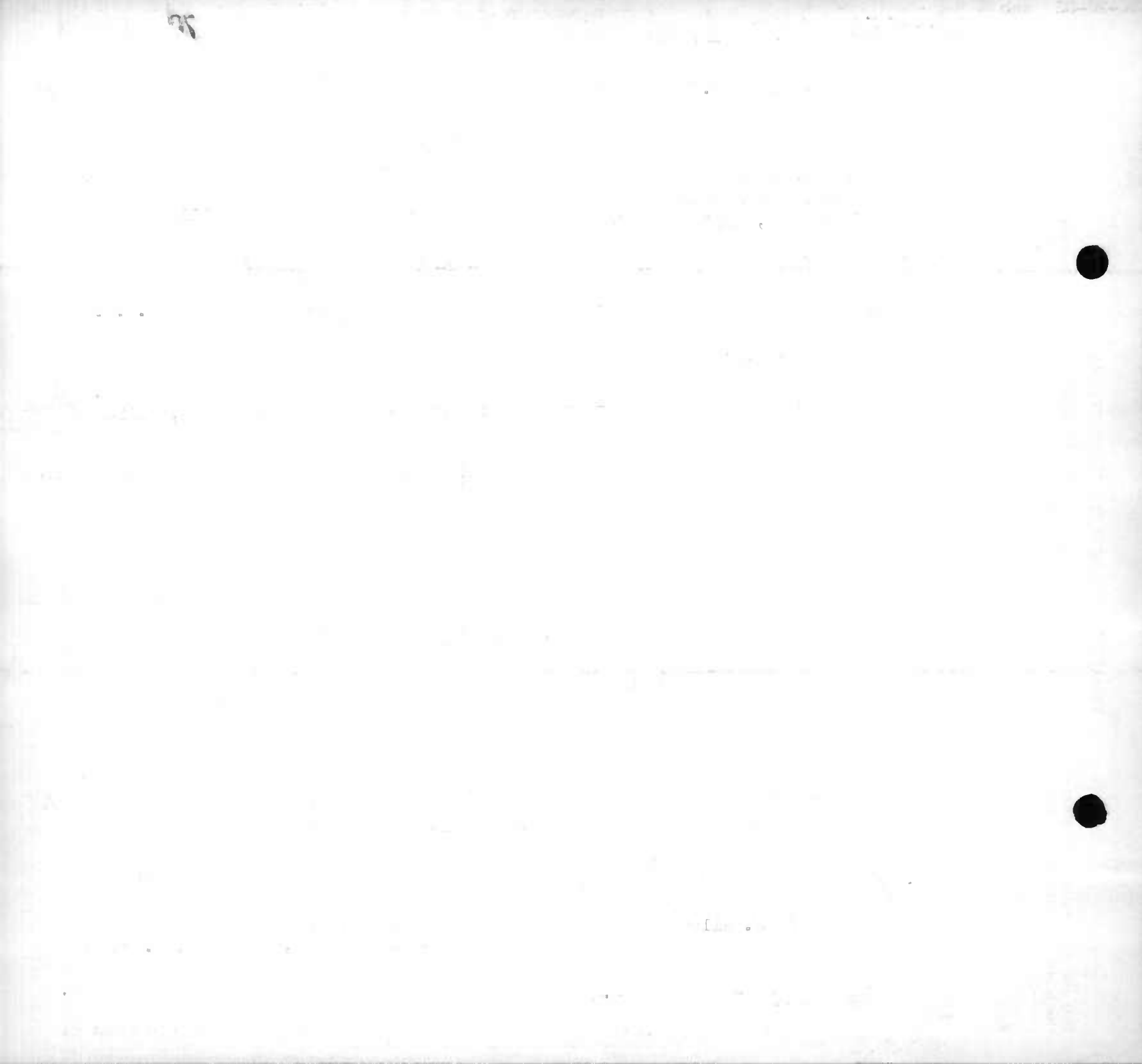
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|----------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1790 | |
| BIRTH NO. D-550 70 1790 | | CERTIFICATE OF DEATH X | |
| 1. NAME OF DECEASED
(Type or Print) Emmar. Dunham | | 2. DATE AND HOUR OF DEATH
7 Feb '70 1:45 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Baltimore City Hospitals
31 4940 Eastern Avenue
Baltimore, Maryland 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore Co.
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 313 Lorraine Avenue 21221 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-28-23 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Housewife | 9. AGE (In years last birthday) 46 |
| 11. BIRTHPLACE (State or foreign country)
Maryland Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Diggs | | 14. MOTHER'S MAIDEN NAME
Anna | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-18-7880 | |
| 17. INFORMANT Nelson Dunham ADDRESS 1146 Langley Rd. 212 | | Records: BCH-4940 Eastern Avenue, 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
410.9 + 250.9 | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Acute Myocardial infarction 1 hr | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | (B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

 | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Diabetes Mellitus | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3-4 yrs | |
| 19A. DATE OF OPERATION
17 Feb 70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
A-U Block | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 7 Feb 19 70 to 7 Feb 19 70 and that (1) (we) lost saw the deceased alive on 7 Feb 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
David J. Riley MD | | 23B. DATE SIGNED
7 Feb 70 | |
| 23C. PHYSICIAN'S NAME (Type) David J. Riley | | 23D. ADDRESS
Baltimore City Hospitals
4940 Eastern Avenue, Baltimore, Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-11-1970 | |
| 24C. NAME of CEMETERY or CREMATORY
Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
Lassahn Funeral Home | | ADDRESS
7401 Belair Road 21 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1791 | |
|---|--|---|---|--|---|
| H-256 70 1791 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) <i>Mamie Hagner</i> | | | 2. DATE AND HOUR OF DEATH
<i>2/13/70 7:28 AM</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>University Hosp</i>
<i>38 Ba 1 to MD</i> | | | A. STATE <i>Maryland</i>
B. COUNTY <i>2102</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>38 Ba 1 to MD</i> | | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <i>Female</i> | | | 6. RACE <i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Bottle Washer</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Distillery</i> | | 8. DATE OF BIRTH
<i>2/15/88</i> |
| 13. FATHER'S NAME
<i>John Smokeween</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Elizabeth Knott</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>no</i> | | | 16. SOCIAL SECURITY NO.
<i>217-01-1548A</i> | | 9. AGE (in years last birthday)
<i>81</i> |
| 17. INFORMANT
<i>Charles Samorodin MD</i> | | | ADDRESS
<i>Univ Hosp</i> | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>immediate</i>
<i>5 days</i> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<i>Atrial Fibrillation</i> | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
1(Month) 1(Day) 1(Yeod) 1(Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/7</i> 19 <i>70</i> to <i>2/13</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>2/13</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Charles S. Samorodin MD</i> | | | 23B. DATE SIGNED
<i>2/17/70</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>Charles S. Samorodin</i> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 24B. DATE
<i>2/16/70</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>St. Olmest Cemetery</i> |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 16 1970</i> | | | 25B. NAME OF REGISTRAR
<i>Robert E. Venable</i> | | 25C. FUNERAL DIRECTOR
<i>John P. ...</i> |
| 26A. LOCATION (City, town, or county)
<i>Baltimore</i> | | | 26B. LOCATION (State)
<i>MD.</i> | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|-------------------------|---|--|---|--|--|--|
| 3-620 | | 70 1792 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1792 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Dolores J. George
DOLORES GEORGE | | | | 2. DATE AND HOUR OF DEATH
2.11.70 5:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
CHURCH HOME AND HOSPITAL
35 Church Home & Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore
C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2358 Searles Rd (22) | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12.20.21 | 9. AGE (in years lost birthday)
48 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Stamper | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Four Roses Distillery | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
AMERICA. | | | | 13. FATHER'S NAME
DANIEL DIETRICH | | | |
| 14. MOTHER'S MAIDEN NAME
BESSIE MILLER. | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
219125637 | | | | 17. INFORMANT (Husband) 2358 Searles Road
Mr. Earl George, Dundalk, Md. 21222 | | | |
| 18. CAUSE OF DEATH
5621 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Pulmonary Edema
Congestive Heart Failure
possible Pulmonary Embolus | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Post op bowel obstruction | | | | | | | |
| 19A. DATE OF OPERATION
2.3.70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Divericulitis | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2.1.1970 to 2.11.1970 .
that (I) (we) last saw the deceased alive on 2.11.1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Prabir K. Bose M.D. DEGREE | | | | 23B. DATE SIGNED
2.11.70. | | 23C. PHYSICIAN'S NAME (Type)
PRABIR K. BOSE M.D. | |
| 23D. ADDRESS
Church Home & Hospital
Baltimore MD 21231 | | | | 23E. FUNERAL DIRECTOR
John J. Duda | | 23F. ADDRESS
7922 Wise Ave. Dundalk, Md. 21222 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-16-70 | | 24C. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
John J. Duda | | 25C. FUNERAL DIRECTOR
John J. Duda | | 25D. ADDRESS
7922 Wise Ave. Dundalk, Md. 21222 | |

2328 24 11 11

24 11 11 11

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2328 24 11 11

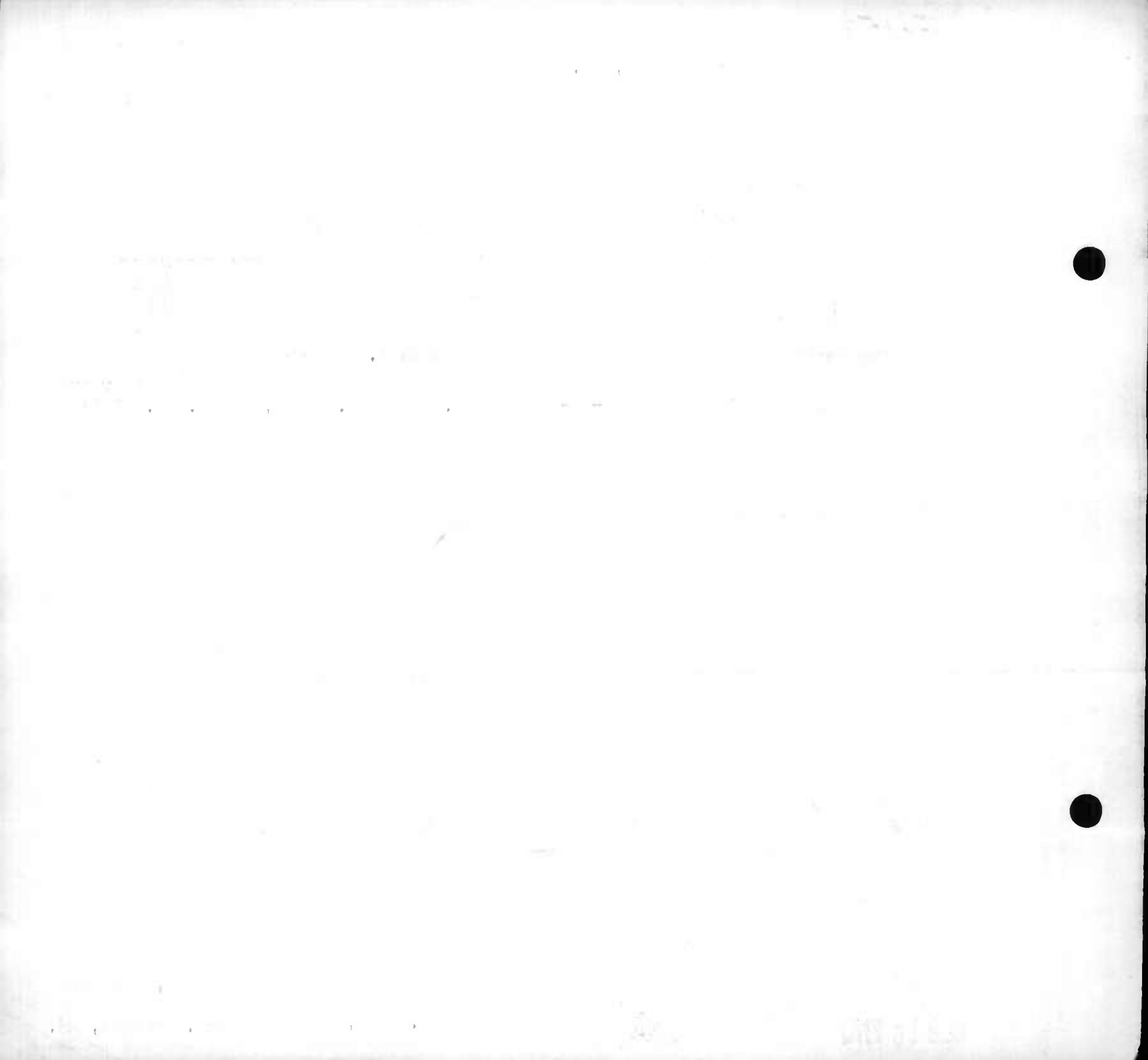
2328 24 11 11

2328 24 11 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. 70 1793 | |
| E-152 70 1793
BIRTH NO. | | Edris Evans, Sr.
1. NAME OF DECEASED (Type or Print) MR. EDRIS EVANS | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
CHURCH HOME AND HOSPITAL
Church Home & Hospital | | 2. DATE AND HOUR OF DEATH
2-13-70 4:05 A.M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
CHURCH HOME AND HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore | |
| 5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RET. MINISTER | | 8. DATE OF BIRTH 6-2-02 9. AGE (In years last birthday) 67 | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
INDIANA | |
| 13. FATHER'S NAME
Evan Evans | | 12. CITIZEN OF WHAT COUNTRY?
AMERICA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes Not War Time | | 14. MOTHER'S MAIDEN NAME
Eliza J. Osborne | |
| 16. SOCIAL SECURITY NO.
213-07-2900 | | 17. INFORMANT
7202 Martha Avenue
Mrs. Thelma M. Evans, Balto. Md. 21219 | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Acute Myocardial Infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic Cardiovascular Disease - years | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerotic Cardiovascular Disease - years | |
| (B) DUE TO, OR AS A CONSEQUENCE OF:
Gastrointestinal Bleeding | | (C) DUE TO, OR AS A CONSEQUENCE OF:
2 days | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Feb. 4 19 70 to Feb. 13 19 70 that (2) (we) last saw the deceased alive on Feb. 13 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Cezar A. Lopez MD | | 23B. DATE SIGNED
2-13-70 | |
| 23C. PHYSICIAN'S NAME (Type)
CEZAR A. LOPEZ MD | | 23D. ADDRESS
CHURCH HOME & HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | |
| 24C. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
John J. Duda | |
| 25C. FUNERAL DIRECTOR
John J. Duda | | ADDRESS
7922 Wise Ave. Dundalk, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

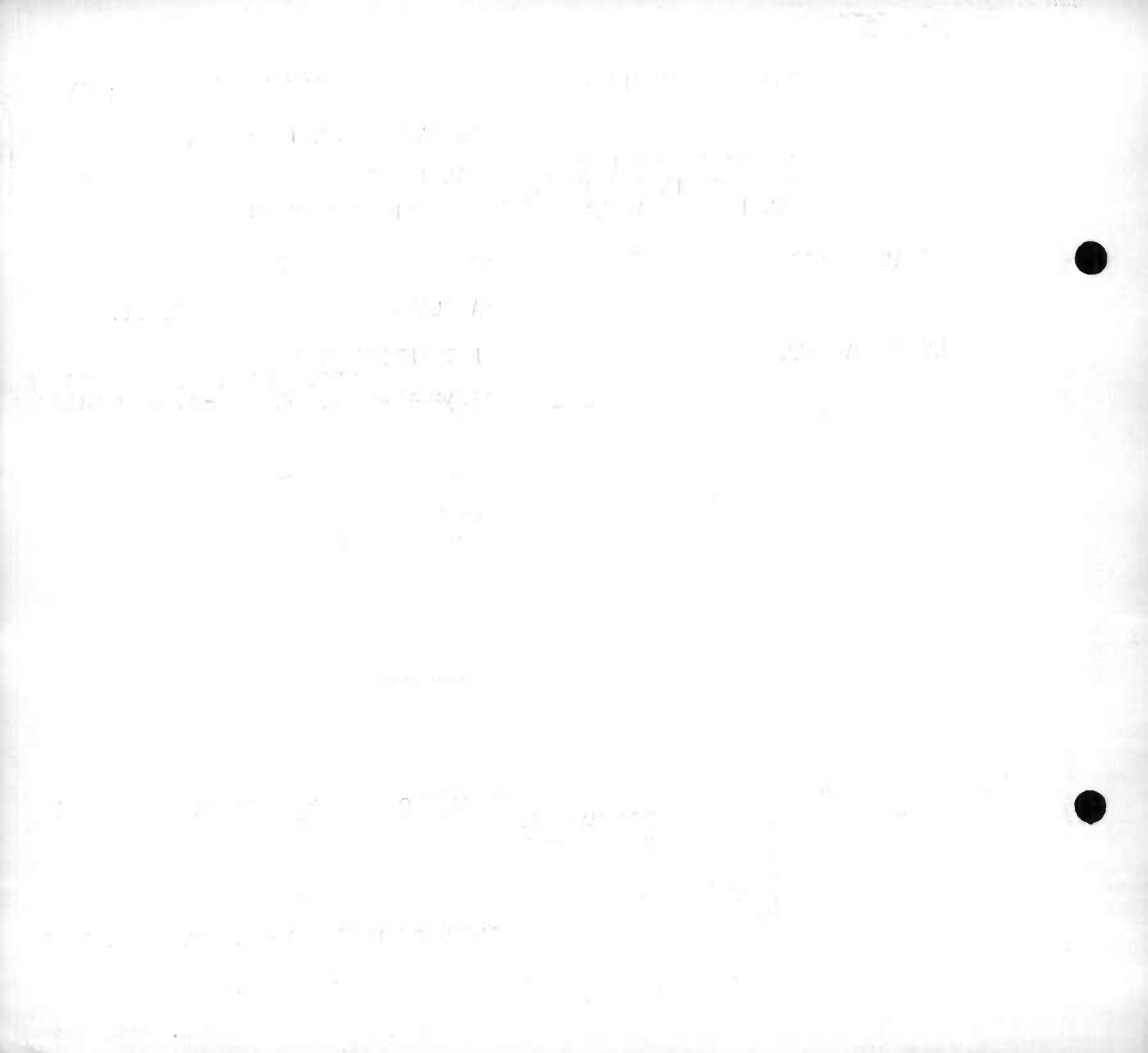
| | | | |
|--|---|---|---|
| <div style="display: flex; justify-content: space-between;"> K-450 70 1794 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> REG. NO. 70 1794 </div> | | | |
| 1. NAME OF DECEASED
(Type or Print) KLEIN, VIRGINIA MARIE | | 2. DATE AND HOUR OF DEATH
FEB. 11, 1970 4:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UNIVERSITY HOSPITAL BALTIMORE | | C. CITY OR TOWN
BALTIMORE | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
1310 MCCURLEY AVE | |
| 5. SEX
F | 6. RACE
CAME | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/15/90 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (in years last birthday)
79 |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
GEORGE GETZ | | 14. MOTHER'S MAIDEN NAME
ANNA SHEA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNK. | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
F. C. DEUSE M.D. | | ADDRESS
UNIVERSITY HOSP. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
208X I | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF:
(B) POLYCYTHEMIA RUBRA PRA
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 wks. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION
2/2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/4 19 70 to 2/11 19 70 that (I) two last saw the deceased alive on 2/11 19 70 and that (in my) own opinion death occurred on the date and hour and from the causes stated above. (I) two (did) did not view the body after death. | | | |
| 23A. SIGNATURE
Frederick C. Deuse | | 23B. DATE SIGNED
2/11/70 | |
| 23C. PHYSICIAN'S NAME (Type)
FREDERICK C. DEUSE | | 23D. ADDRESS
UNIVERSITY HOSPITAL BALT. | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 24B. DATE
2/16/70 | 24C. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | 24D. LOCATION (City, town, or county) (State)
BALTA MD |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| | | 25C. FUNERAL DIRECTOR
E. S. MacVail | |
| | | ADDRESS
301 Frederick Rd Balt. MD 21228 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 70 1795 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. 70 1795 | |
|--|--|--|--|---|---|
| 1. NAME OF DECEASED
(Type or Print) FREEMAN, HARRIETT | | | 2. DATE AND HOUR OF DEATH
FEBRUARY 10, 1970 2:05A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE CO. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MARYLAND 21229 | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX FEMALE 6. RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
02 06 04 | | 9. AGE (In years last birthday) 66 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
LLOYD RANDALL | | | 14. MOTHER'S MAIDEN NAME
MINERVIE (STEWART) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
214-12-8930 | | 17. INFORMANT Mr. William Graffin ADDRESS 223 Winters Lane |
| 18. 441.1 I CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) XXX YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 9 19 70 to FEBRUARY 10 19 70 that (I) (we) last saw the deceased alive on FEBRUARY 10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.
23A. SIGNATURE M. A. Graffin 23B. DATE SIGNED 2/10/70
23C. PHYSICIAN'S NAME (Type) M. A. Graffin 23D. ADDRESS CATON & WILKENS AVES. BALTO MD. 21229
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 2/14/70 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md
25A. DATE REC'D BY HEALTH DEPT. FEB 16 1970 25B. NAME OF REGISTRAR 220 E. Fisher St. MD. 25C. FUNERAL DIRECTOR Nutter Funeral Home ADDRESS 3035 W. North Avenue | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

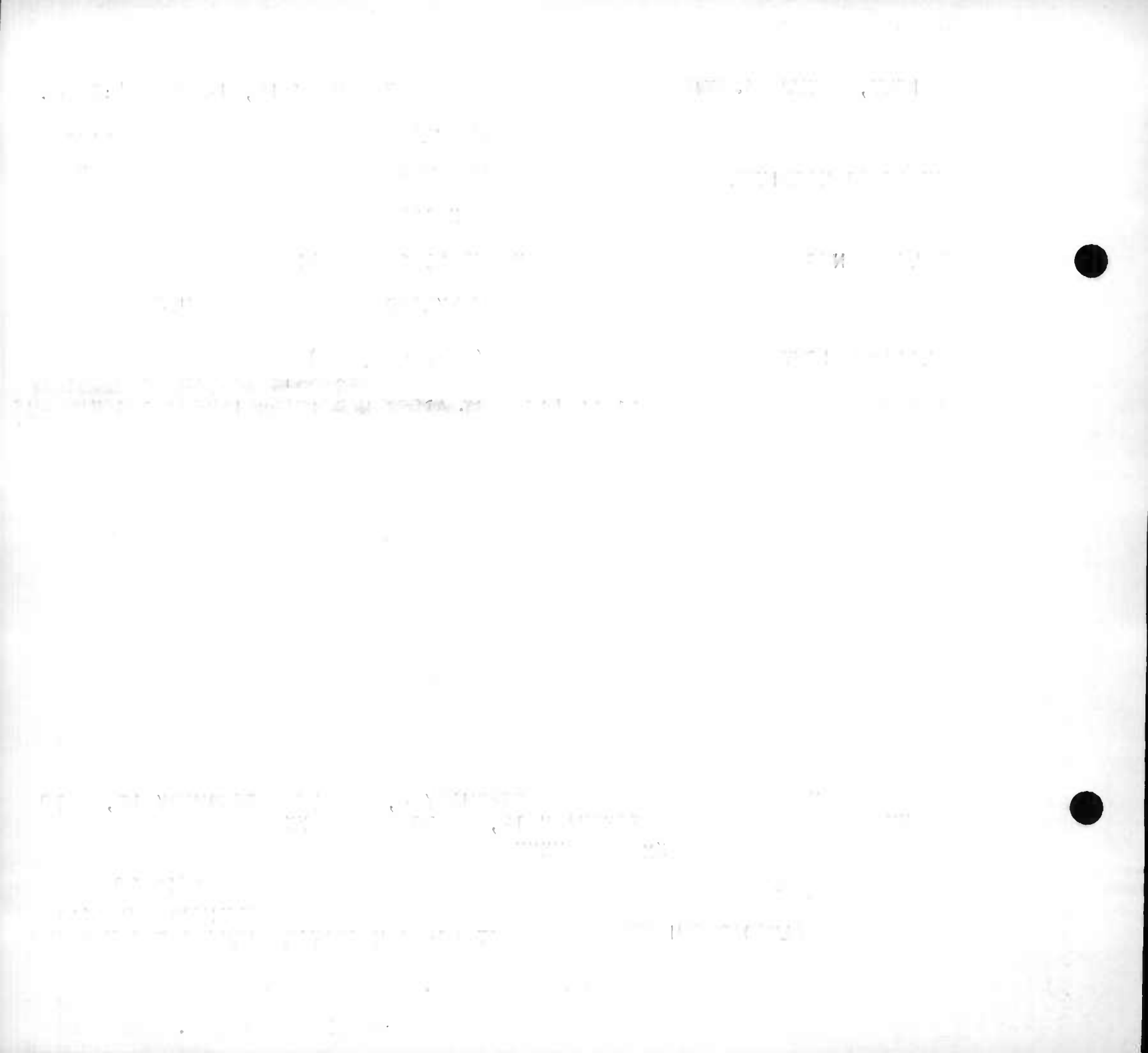
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
|--|--|--|--|
| Thelma Donnell | | 8:30 PM Feb 17 1970 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| 18 University Hospital | | A. STATE MD Maryland B. COUNTY Balto 1608 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | Balto YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 711 Linnard 21229 | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/3/23 |
| | | 9. AGE (In years last birthday) 46 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| Switch Board-Operator | | Maryland | |
| 13. FATHER'S NAME James Holt | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. MOTHER'S MAIDEN NAME Arleta Payne | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-14-7814 | |
| 17. INFORMANT Mr. James Holt | | ADDRESS 711 Linnard Street | |
| 18. 450 X 41303.9 CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Pulmonary Edema | |
| ANTECEDENT CAUSES | | DUE TO, OR AS A CONSEQUENCE OF: | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Pulmonary Embolus | |
| | | DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Alcoholism, Gout, Pancreatitis, GI Bleeding | |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | 20B. (IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/23 19 70 to 2/7 19 70 that (I) (we) last saw the deceased alive on 2/7 19 70 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Ernest S. Sears Jr. MD | | 23B. DATE SIGNED 2/17/70 | |
| 24A. PHYSICIAN'S NAME (Type) | | 24B. ADDRESS 22 S. Greene St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-11-70 | |
| 24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) Baltimore Co., (State) Md | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 16 1970 | | 25B. NAME OF REGISTRAR Robert E. Taylor, R.D. | |
| 25C. FUNERAL DIRECTOR Nutter Funeral Home | | ADDRESS 3035 W. North Avenue | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

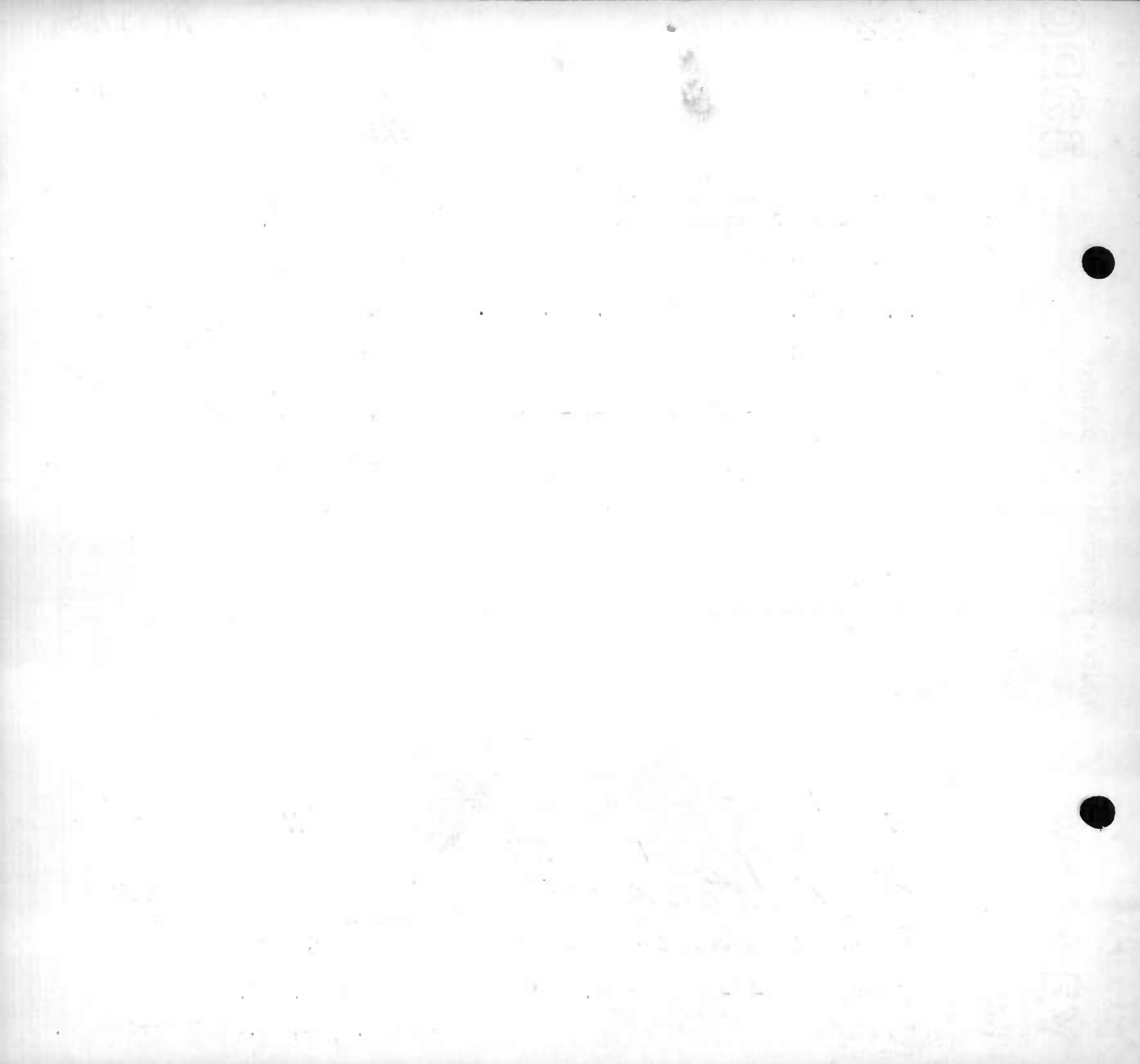
| | | | |
|---|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. <u>70 1797</u> | |
| W-623 70 1797 | | | |
| BIRTH NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print)
WRIGHT, ARTHUR A. | | FEBRUARY 12, 1970 4:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST AGNES HOSPITAL | | A. STATE MARYLAND
B. COUNTY Howard | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN HANOVER
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER
BOX 122 | | | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
07 27 28 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Custodian | | 9. AGE (In years last birthday)
41 | 11. BIRTHPLACE (State or foreign country)
MARYLAND |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
ALFRED WRIGHT | | 14. MOTHER'S MAIDEN NAME
(Virgie O. Cook) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)
Korean | | 16. SOCIAL SECURITY NO.
219228415 | |
| | | 17. INFORMANT
Mr. Alfred Wright Box 122 Hanover, Md. | |
| 18. 5-71-9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Acute Pancreatitis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Liver Cirrhosis | | | |
| (C) Hepatic Encephalopathy | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 8, 19 70 to FEBRUARY 12, 19 70 that (X) (we) last saw the deceased alive on FEBRUARY 12, 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (We) (did) (X) (X) view the body after death. | | | |
| 23A. SIGNATURE
 | | 23B. DATE SIGNED
2/12/70 | |
| 23C. PHYSICIAN'S NAME (Type)
SALVADOR QUIROZ | | 23D. ADDRESS
BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | |
| 24C. NAME of CEMETERY or CREMATORY
Baltimore, National Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, Jr. | |
| 25C. FUNERAL DIRECTOR
Nutter Funeral Home | | ADDRESS
3035 W. North Avenue | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

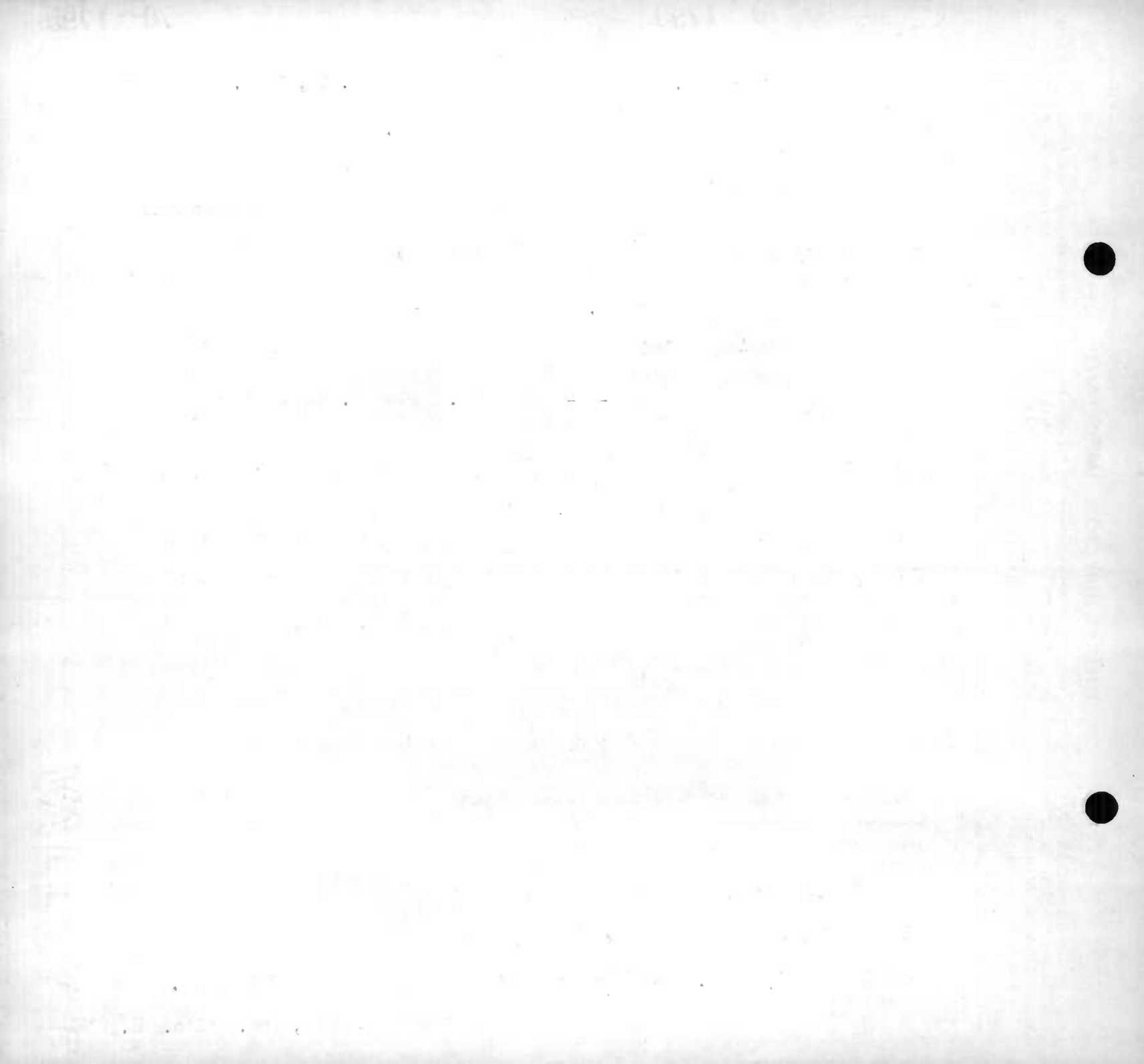
| F-600 70 1798 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1798 | |
|---|------------------|---|-----------------------------|--|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | | | FERRI, Joseph Lewis | | February 12, 1970 11:00 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | | A. STATE
Maryland | | B. COUNTY
1202 | |
| | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
3045 St Paul St. | | | | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/11/95 | 9. AGE (In years last birthday)
74 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
P.R. Manager. | | 10B. KIND OF BUSINESS OR INDUSTRY
Metro Lic. Bev. Assn. New York | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Julius Ferri | | | | 14. MOTHER'S MAIDEN NAME
Mamie Seigal | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 7/13/17 - 1/30/19 | | 16. SOCIAL SECURITY NO.
212-18-4881A | | 17. INFORMANT
VA Hospital Records
Baltimore, Maryland 21218 | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Bronchogenic Carcinoma
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from February 10th 1970 to February 12th 1970, that (1) (we) last saw the deceased alive on February 12th 1970 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Ronald S. Pototsky M.D. | | | | | | 23B. DATE SIGNED
2/12/70 | |
| 23C. PHYSICIAN'S NAME (Type)
RONALD S. POTOTSKY M.D. | | 23D. ADDRESS
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-16-70 | | 24C. NAME OF CEMETERY or CREMATORY
Balto. Nat'l | | 24D. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. [Signature] | | 25C. FUNERAL DIRECTOR
Leonard J. Buck, Inc., 5305 Harford Rd. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

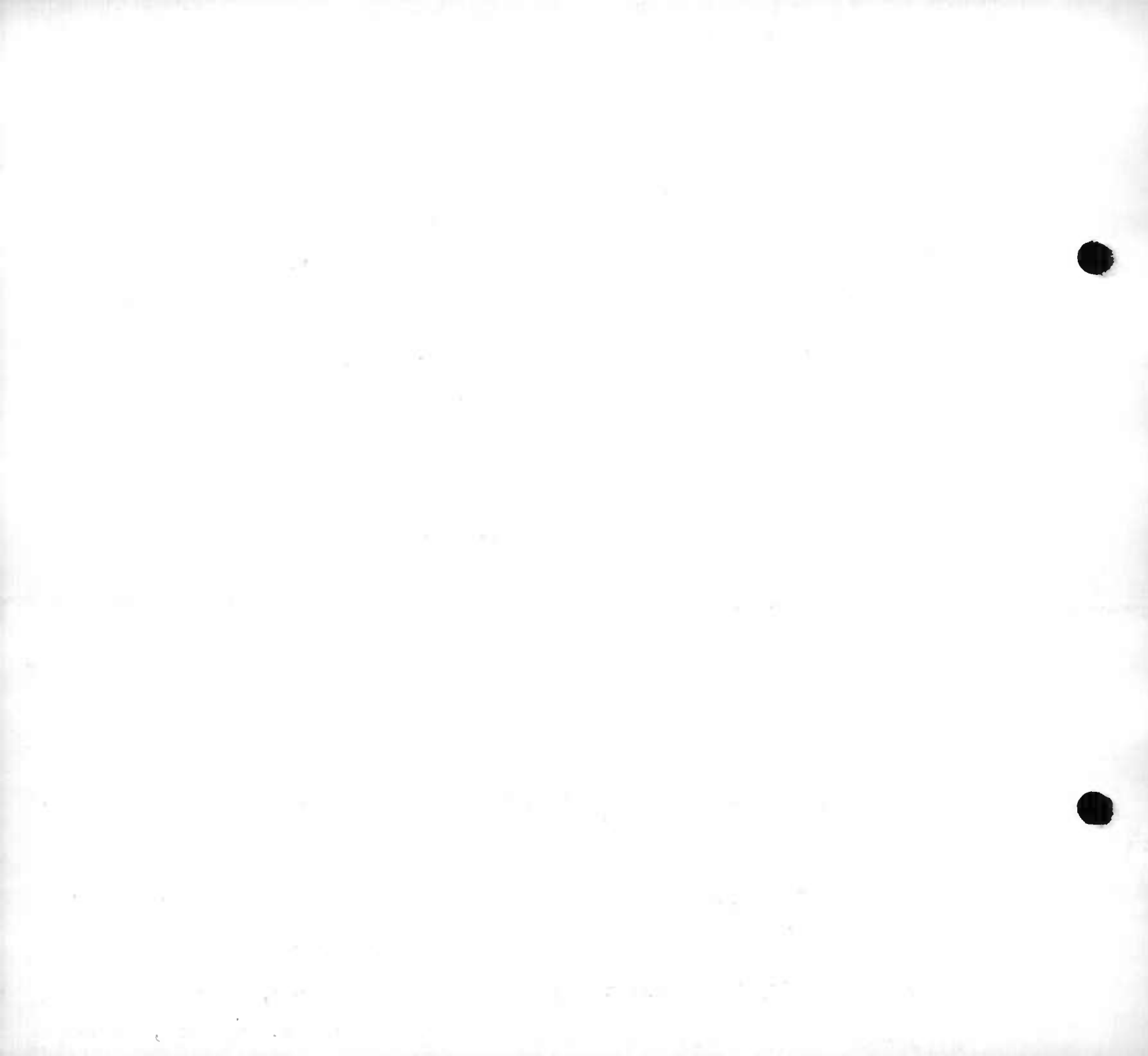
| Baltimore City Health Department | | | | REG. NO. | |
|--|--|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> S-350 70 1799 </div> | | | | <div style="display: flex; justify-content: space-between;"> 70 1799 </div> | |
| <div style="display: flex; justify-content: space-between;"> <div> BIRTH NO.
 1. NAME OF DECEASED
 (Type or Print) </div> <div> 2. DATE AND HOUR OF DEATH
 Feb. 11, 1970. </div> </div> | | | | 9 ³⁰ - P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<div style="text-align: center;"> 44 Union Memorial Hospital </div> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: | |
| 5. SEX
Male | | | | 6. RACE
White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
March 10, 1898 | |
| 9. AGE (In years last birthday) 71 | | | | 10. CITIZEN OF WHAT COUNTRY?
USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Trusco Co. | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Jeremiah Sutton | | | | 14. MOTHER'S MAIDEN NAME
Bertha Poole | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
Yes | | | | 16. SOCIAL SECURITY NO.
212-07-7961 | |
| 17. INFORMANT
Mrs. Thelma N. Sutton | | | | ADDRESS
(Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
Acute coronary Occlusion
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
arteriosclerosis
(B) Cardio-vascular disease
DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
12 years
10 years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Hypo-thyroidism | | | | | |
| 19A. DATE OF OPERATION
0 - | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 8 1968 to Feb 11 1970 and that (I) (we) last saw the deceased alive on Feb 11 1970 and that (I) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] | | | | 23B. DATE SIGNED
2/13/70 | |
| 23C. PHYSICIAN'S NAME (Type)
G. J. SAWYER, JR. M.D. | | | | 23D. ADDRESS
4808 Hargrave Rd. Balto Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/14/70. | | 24C. NAME OF CEMETERY or CREMATORY
Moreland Memorial Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | | | 25B. NAME OF REGISTRAR
Robert E. Taylor, R.D. | |
| 25C. FUNERAL DIRECTOR
Leonard J. Buck, Inc. Balto. Md. 21214 | | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|---------------------|--|---|--|---|
| 1-200 | | 70 | 1800 | 70 1800 | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
MICHAEL F. SMITH LEWIS | | | 2. DATE AND HOUR OF DEATH
12 February 1970 6 15 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY BALTO. | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
University of Maryland Hospital | | | C. CITY OR TOWN
Lutherville | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | E. STREET AND NUMBER
223 Division Ave | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/20/56 | 9. AGE (In years last birthday)
13 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | 10B. KIND OF BUSINESS OR INDUSTRY
— | 11. BIRTHPLACE (State or foreign country)
MD | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Edwin L. Lewis | | | 14. MOTHER'S MAIDEN NAME
Doris Blake | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
— | | 16. SOCIAL SECURITY NO.
— | 17. INFORMANT
Mr Edwin L. Lewis | | ADDRESS
Same |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
205.0 I | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Gram Neg. Sepsis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
60 hrs. |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION last. | | | (B) Leukopenia 2° drug Rx
DUE TO, OR AS A CONSEQUENCE OF: | | 72 hrs. |
| | | | (C) Acute Myeloid Leukemia | | 4 yrs. |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1 January 19 70 to 12 February 19 70 that (I) (we) last saw the deceased alive on 12 February 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Mark M. Applefeld, MD | | | | 23B. DATE SIGNED
12 February, 1970 | |
| 23C. PHYSICIAN'S NAME (Type)
MARK M. Applefeld MD | | | | 23D. ADDRESS
University of Maryland Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. LOCATION (City, town, or county) | | (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, MD | | 25C. FUNERAL DIRECTOR
Leonard J. Rick Inc. Baltimore, Maryland | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1801</u> |
|--|--|---|--|-------------------------|
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print)
<div style="text-align: center; font-size: 1.2em;">Howard Roland Colburn</div> | | 2. DATE AND HOUR OF DEATH
<div style="display: flex; justify-content: space-between;"> Feb. 13, 1970 3:45 A M. </div> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> FULL NAME OF HOSPITAL OR INSTITUTION
 <div style="font-size: 1.2em;">2X US Public Health Service Hospital</div> <div style="font-size: 1.2em;">3100 Wyman Parkway</div> </div> <div style="width: 50%;"> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

 </div> </div> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> A. STATE
 <div style="font-size: 1.2em;">Md.</div> </div> <div style="width: 50%;"> B. COUNTY
 <div style="font-size: 1.2em;">2702</div> </div> </div> | | |
| 5. SEX
<div style="display: flex; justify-content: space-around;"> M W </div> | | 6. RACE
<div style="display: flex; justify-content: space-around;"> W </div> | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<div style="font-size: 1.2em;">5/11/95</div> | | |
| 9. AGE (In years last birthday)
<div style="font-size: 1.2em;">74</div> | | 10. COUNTRY OF BIRTH
<div style="font-size: 1.2em;">Md.</div> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<div style="font-size: 1.2em;">Retired</div> | | 10B. KIND OF BUSINESS OR INDUSTRY
<div style="font-size: 1.2em;">Painter</div> | | |
| 11. BIRTHPLACE (State or foreign country)
<div style="font-size: 1.2em;">Md.</div> | | 12. CITIZEN OF WHAT COUNTRY?
<div style="font-size: 1.2em;">USA</div> | | |
| 13. FATHER'S NAME
<div style="font-size: 1.2em;">Thomas Colburn</div> | | 14. MOTHER'S MAIDEN NAME
<div style="font-size: 1.2em;">Mary Mc Abee</div> | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<div style="display: flex; justify-content: space-around;"> Yes USN 1914-1931 </div> | | 16. SOCIAL SECURITY NO.
<div style="font-size: 1.2em;">216-46-7433</div> | | |
| 17. INFORMANT
<div style="font-size: 1.2em;">Records- US PHS Hospital, Balto, Md.</div> | | 18. ADDRESS
 | | |
| 18. CAUSE OF DEATH
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

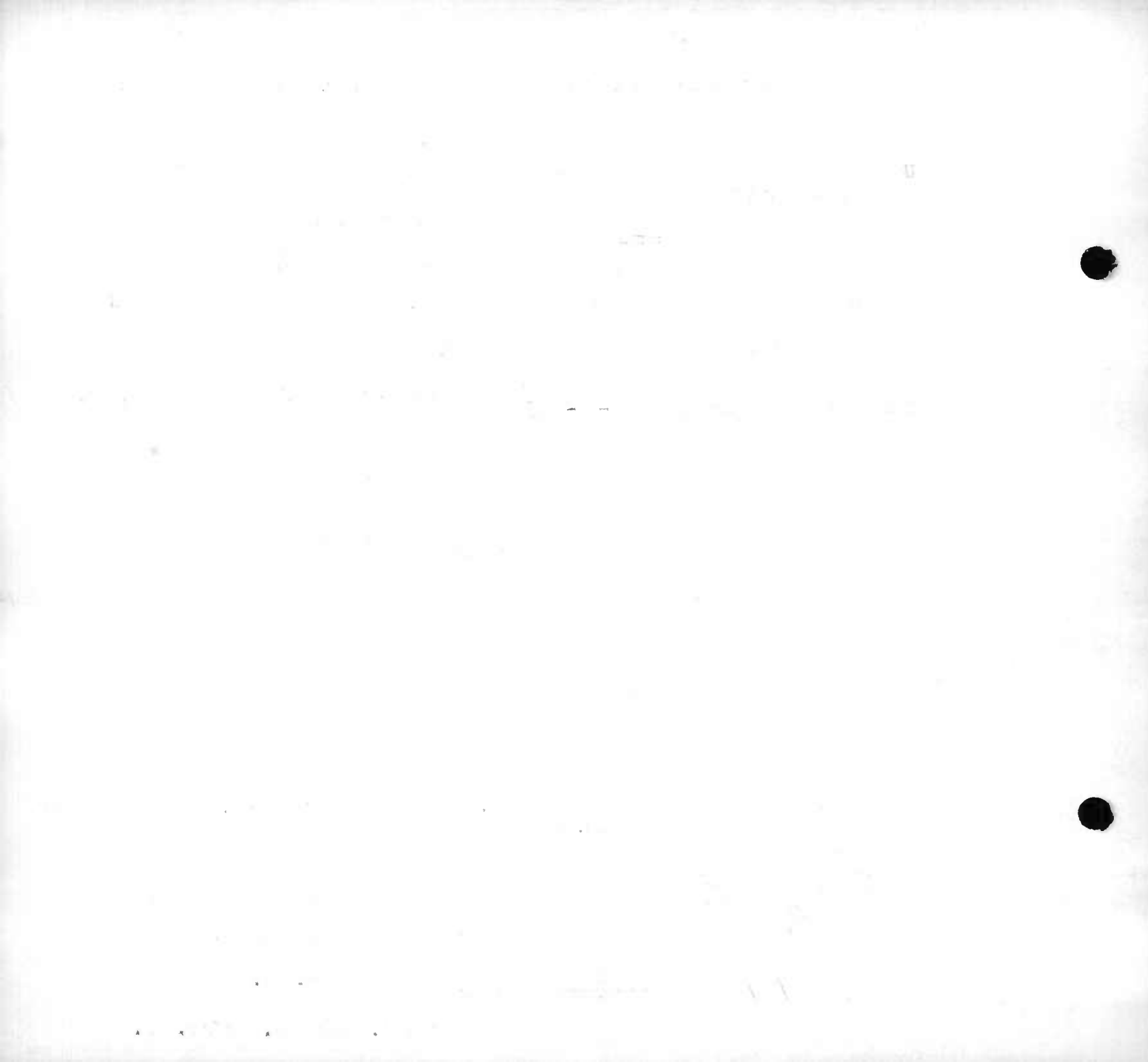
 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

 </div> </div> | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> (A) IMMEDIATE CAUSE
 <div style="font-size: 1.2em;">Cardiac arrest</div> </div> <div style="width: 35%;"> DUE TO, OR AS A CONSEQUENCE OF:

 </div> </div> | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> (B) Antecedent Cause
 <div style="font-size: 1.2em;">Coronary heart disease</div> </div> <div style="width: 35%;"> DUE TO, OR AS A CONSEQUENCE OF:

 </div> </div> | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> (C) Antecedent Cause
 <div style="font-size: 1.2em;">Paraphimosis</div> </div> <div style="width: 35%;"> DUE TO, OR AS A CONSEQUENCE OF:

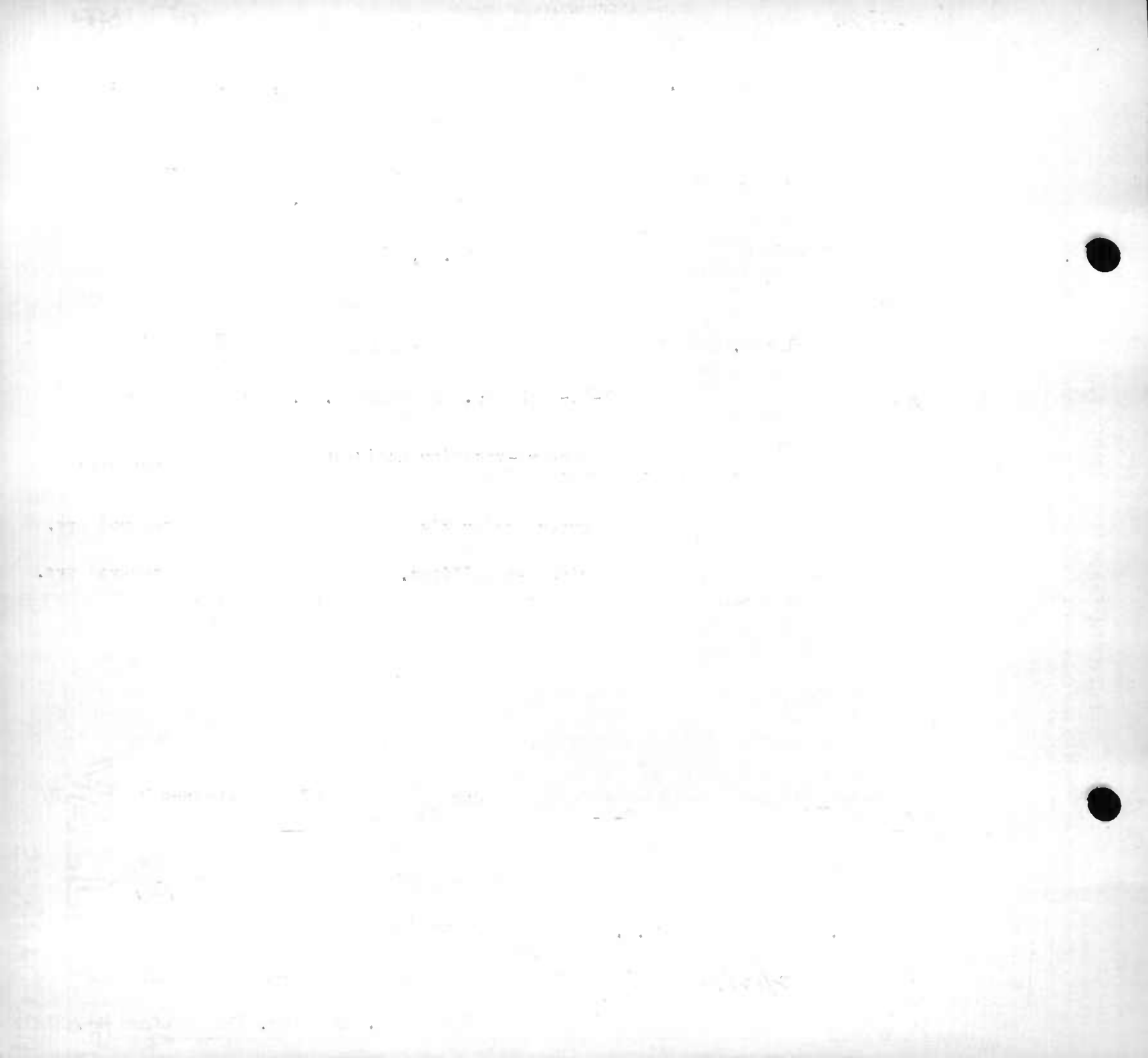
 </div> </div> | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
 | | | | |
| 19A. DATE OF OPERATION
 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | |
| 20A. AUTOPSY? (Yes or No)
<div style="font-size: 1.2em;">No</div> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
 | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
 | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
 | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
 | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
 | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR?
 | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>Feb. 10</u> <u>19 70</u> to <u>Feb. 13</u> <u>19 70</u> that (1) (we) last saw the deceased alive on <u>Feb. 13</u> <u>19 70</u> and that in (my) (our) opinion death occurred on the date <u>Feb. 13</u> <u>19 70</u> and hour and from the causes stated above. (1) (We) (did) (not) view the body after death. | | | | |
| 23A. SIGNATURE
<div style="font-size: 1.2em;">Philip Littman</div> | | 23B. DATE SIGNED
<div style="font-size: 1.2em;">2/13/70</div> | | |
| 23C. PHYSICIAN'S NAME (Type)
<div style="font-size: 1.2em;">Philip Littman</div> | | 23D. ADDRESS
<div style="font-size: 1.2em;">3100 WYMAN PK DR Balto</div> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<div style="font-size: 1.2em;">Burial</div> | | 24B. DATE
<div style="font-size: 1.2em;">2/16/70</div> | | |
| 24C. NAME OF CEMETERY OR CREMATORY
<div style="font-size: 1.2em;">London Park</div> | | 24D. LOCATION (City, town, or county) 1 State
<div style="font-size: 1.2em;">Balto, Md.</div> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<div style="font-size: 1.2em;">FEB 16 1970</div> | | 25B. NAME OF REGISTRAR
<div style="font-size: 1.2em;">John E. Gable</div> | | |
| 25C. FUNERAL DIRECTOR
<div style="font-size: 1.2em;">Leonard J. Ruck Inc.</div> | | 25D. ADDRESS
<div style="font-size: 1.2em;">Balto, Md.</div> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1802 | |
|--|-----------|--|---|--|---|
| <div style="display: flex; justify-content: space-between;"> W-524 70 1802 70 1802 </div> | | | | | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Mildred C. Wenzel | | | February 9, 1970 8:08 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE | | |
| | | | Maryland | | |
| 00 5615 Tramore Road | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? |
| | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER | | |
| | | | 5615 Tramore Road | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Female | Caucasian | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Oct. 6, 1894 | 75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Homemaker | | | Maryland | | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Charles W. Hebbel | | | Catherine ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT |
| No | | | 213-32-8372 | | Mr. Frederick C. A. Wenzel |
| | | | ADDRESS | | Same |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | cerebro-vascular accident | | |
| ANTECEDENT CAUSES | | | (A) IMMEDIATE CAUSE | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | arteriosclerosis | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | diabetes mellitus. | | |
| | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 19 69 to February 9 19 70, that (I) (we) last saw the deceased alive on 2-8-19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| E. Ellsworth Cook M.D. | | | | 2/10/70 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| E. Ellsworth Cook M.D. | | | | 2431 Maryland Avenue | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/12/70 | | Loudon Park Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 16 1970 | | Robert E. Taylor, Jr. | | Leonard J. Buck Inc. 5305 Harford Rd. 21214 | |

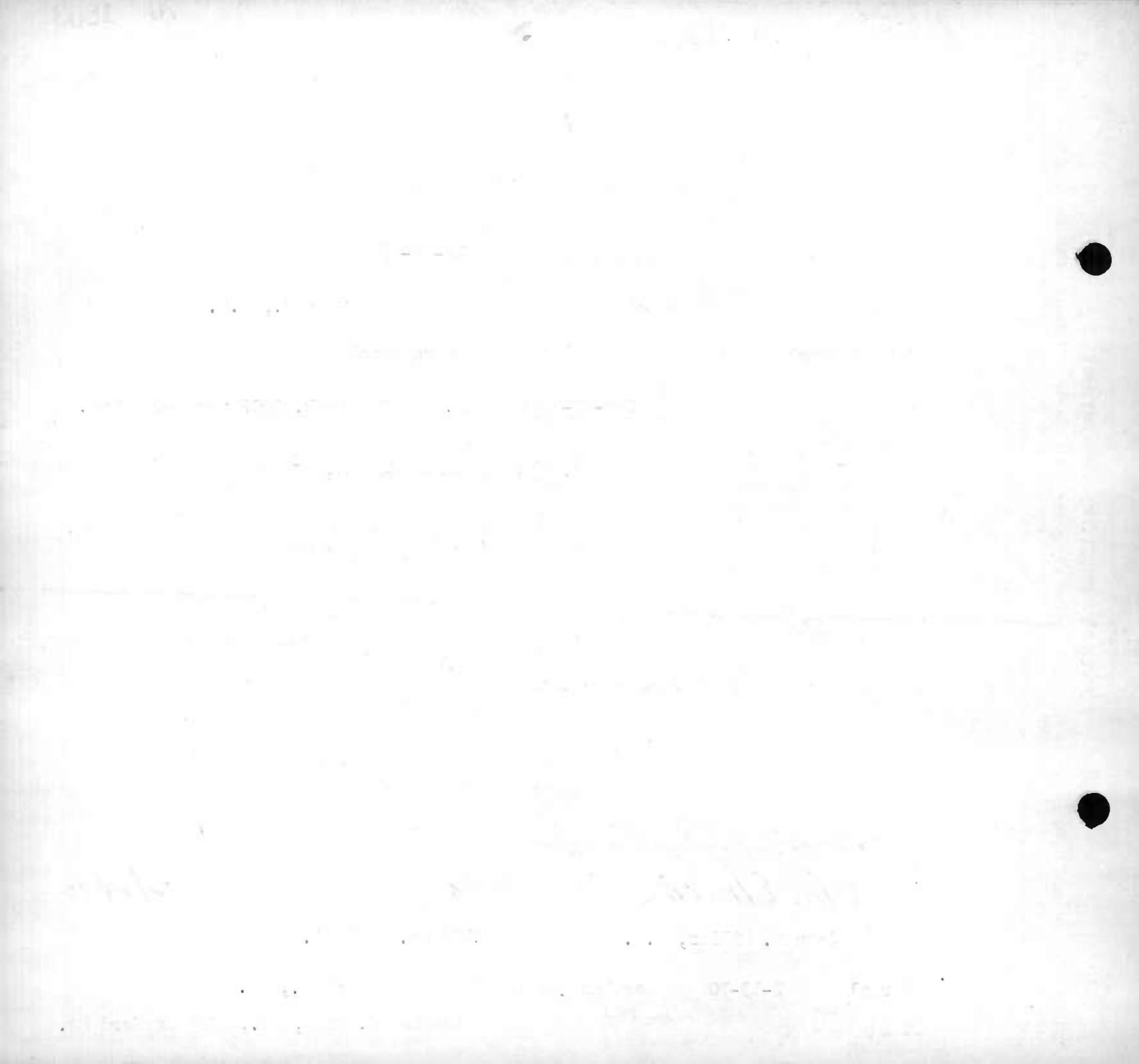


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print) JAMES MAREK | | 2. DATE AND HOUR OF DEATH
2/19/70 4:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

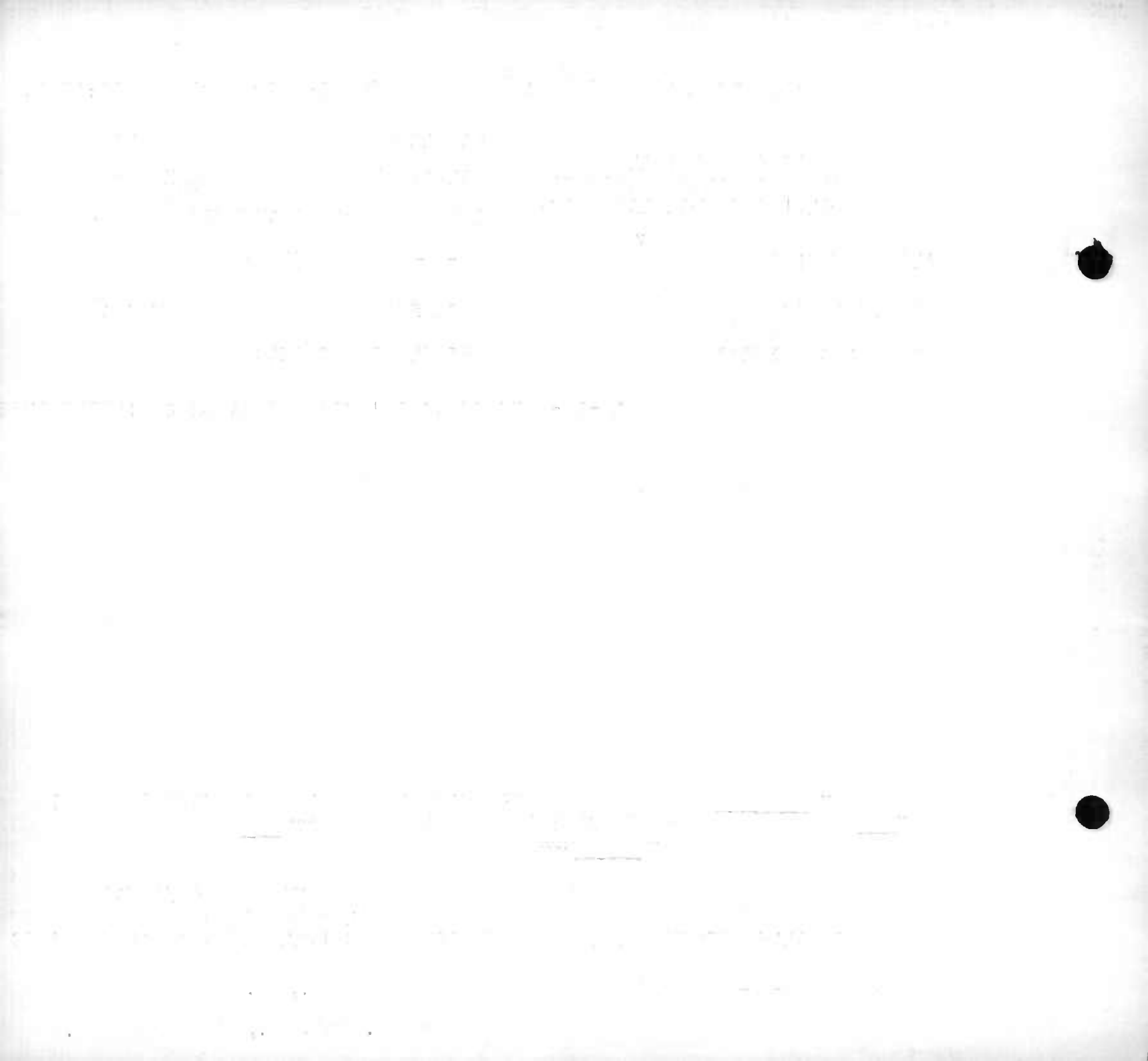
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
MARYLAND GENERAL HOSP. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 2735
D. STREET ADDRESS (If rural, give location)
3012 E. NORTHERN PARKWAY | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
12-24-05 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY
Hotel | 9. AGE (In years lost birthday)
64 |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. Wash., D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Albert Marek | | 14. MOTHER'S MAIDEN NAME
Anna Stach | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-01-5956 | |
| 17. INFORMANT
Mrs. Myrtle Marek, 3012 Northern Pkwy. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
162.1 I
Rt. Pleural effusion, massive
Antecedent Causes
Bronchogenic Carcinoma, Rt. luncy, resected
25 days | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | |
| 19. DATE OF OPERATION
31-16-70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma, RLL | |
| 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
John E. Miller | | 23B. DATE SIGNED
2/19/70 | |
| 23C. PHYSICIAN'S NAME (Type)
John E. Miller, M.D. | | 23D. ADDRESS
M.D. 1116 St. Paul St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-13-70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Moreland Memorial | | 24D. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
John E. Miller | |
| 25C. FUNERAL DIRECTOR
Leonard G. Back, Inc., 5305 Harford Rd. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------|---|------------------|---|-----------------------------|--|------------------------------|
| F-652 | | 70 1804 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1804 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| FRANKOS, HARRY DEMETRIOS (Demitrios) | | | | FEBRUARY 10, 1970 10:35 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 ST AGNES HOSPITAL
CATON & WILKENS AVENUES
BALTIMORE, MARYLAND 21229 | | | | A. STATE MARYLAND
B. COUNTY 1201 21218
C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3614 GREENMOUNT AVENUE | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | 12. CITIZEN OF WHAT COUNTRY? |
| MALE | WHITE | | 5-20-07 | 64 62 | | | U S A |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| RESTAURANTEUR | | | | GREECE | | U S A | |
| 13. FATHER'S NAME (Demitrios) | | | | 14. MOTHER'S MAIDEN NAME | | | |
| DEMETRIOS FRANKOS | | | | PENELOPE DOUCHEAS Dotsicas | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | 215-34-6575 | | ST AGNES' RECORDS CATON & WILKENS AVES | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: hraemia.
(B) Chronic Nephritis.
DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLIEING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 7 19 70 to FEBRUARY 10 19 70 that (X) (we) last saw the deceased alive on FEBRUARY 10 19 70 and that (in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) view the body after death. | | | | | | | |
| 23A. SIGNATURE
M. G. ALLEN MERSH, M.D. | | | | 23B. DATE SIGNED
02/10/70 | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS
BALTO MD 21229
ST AGNES HOSPITAL CATON & WILKENS AVES | | | | 23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 23F. DEGREE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2-13-70 | | Greek Orthodox | | Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 16 1970 | | Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|--|--|---|
| S-620 70 1805 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1805 | |
| BIRTH NO. | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Louis J. Scheurich</u> | | | 2. DATE AND HOUR OF DEATH
<u>2/10/70</u> <u>11:40 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>2407 Mayfield Rd.</u>
<u>Balto. Md. 21213</u> | | | A. STATE <u>Md.</u>
B. COUNTY <u>831</u> | | |
| | | | C. CITY OR TOWN
<u>Balto</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<u>2407 Mayfield Rd.</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 13, 1897</u> | 9. AGE (In years last birthday)
<u>72</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Postal Clerk</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | 13. FATHER'S NAME
<u>August Scheurich</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>Barbara Maurer</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> <u>WW 11</u> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
<u>Mrs Theresa Scheurich</u> | | |
| 18. CAUSE OF DEATH | | | ADDRESS
<u>Same</u> | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
<u>153.8 I</u> | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Acute Respiratory Failure</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hr.</u> |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) <u>Carcinoma of the colon & widespread</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>intraabdominal + pulmonary metastases.</u> | | <u>8 mos -</u> |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No.</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>September 7 1969</u> to <u>Feb. 10 1970</u>
that (1) (we) last saw the deceased alive on <u>2/10 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>E. Lee Robbins</u> | | | 23B. DATE SIGNED
<u>2/10/70</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>E. Lee Robbins</u> | | | 23D. ADDRESS
<u>812 Mockingbird La. 21204-</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/14/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore. Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 16 1970</u> | | 25B. NAME OF REGISTRAR
<u>266 E. Taylor, Md.</u> | | 25C. FUNERAL DIRECTOR
<u>Leonard J. Ruck Inc Baltimore, Maryland</u> | |

1

J-520 70 1806 BALTIMORE CITY HEALTH DEPARTMENT

70 1806

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67-14494 REG. NO.

1. NAME OF DECEASED (Type or Print) **DARRELL DUALLA JONES**

2. DATE OF DEATH Known ☐ Estimated ☐ Month Day Year Hour **2 13 70 7:46 a.m.**

3. DATE PRONOUNCED DEAD Month Day Year Hour **February 13, 1970 7:46 a.m.**

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Johns Hopkins Hospital D.O.A.**

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE **Maryland** B. COUNTY **802**

6. SEX **Male** 7. RACE **Negro** 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN **Balto.** D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH **7-26-67** 10. AGE (In years last birthday) **2** 11. BIRTHPLACE (State or foreign country) **BALTO. Md** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **JAMES BANKS** 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **NONE** 15. MOTHER'S MAIDEN NAME **PARTHERIA JONES**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **NONE** 17. SOCIAL SECURITY NO. **1940 Pearlman Pl.** 18. INFORMANT **PARTHERIA JONES** ADDRESS **1940 Pearlman Pl.**

19. **E890X** CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

(A) IMMEDIATE CAUSE **Conflagration** DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:

20A. DATE OF OPERATION **2/16/70** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED **Home** 21. AUTOPSY? (Yes or No) **No**

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Home** 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **1945 Pearlman Place 802**

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) **2 13 70 7a.m.** 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? **Subject in house fire**

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Isidore Mihalakis, M.D.** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **2/13/70**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **2/16/70** 24C. NAME OF CEMETERY OR CREMATORY **mt. Calvary** 24D. LOCATION (City, town or county) (State) **A.A. County, Md**

25A. DATE REC'D BY HEALTH DEPT. **FEB 16 1970** 25B. NAME OF REGISTRAR **E. J. Jones, M.D.** 25C. FUNERAL DIRECTOR **Joseph L. Rock, Jr.** ADDRESS **1304 N. Calvary**

VS 151-REV. 1/1/68

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1807

BIRTH NO. 64-06448

| | | | | | |
|--|-------------------------|--|----------------------------------|--|--|
| 1. NAME OF DECEASED
(Type or Print) JACKLYN JACQUELINE JONES | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/> 2 13 70
Month Day Year | | Hour 7:46 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
Johns Hopkins Hospital D.O.A. | | 3. DATE PRONOUNCED DEAD
Month Day Year
February 13, 1970 | | Hour 7:46 a.m. | |
| (If not in hospital or institution, give street address or location) | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE Maryland
B. COUNTY 802 | |
| 6. SEX
Female | 7. RACE
Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Balto. | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
Mar 1, 1964 | | 10. AGE (In years last birthday) 5
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | E. STREET AND NUMBER
1945 Pearlman Place | |
| 11. BIRTHPLACE (State or foreign country)
BALTO., Md. | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
JAMES BANKS | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME
PANTHERIA JONES | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
PANTHERIA JONES 1940 Pearlman Pl. | |
| 19. E 890 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Conflagration
DUE TO, OR AS A CONSEQUENCE OF:

(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
no | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
1945 Pearlman Place 802 | |
| 22D. TIME OF INJURY (APPROX.)
Month (Month) (Day) (Year) (Hour)
2 13 70 7 a.m. | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subject in house fire | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

ACTUAL SIGNATURE Isidore Mihalakis M.D.
EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 2/13/70 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary | |
| 24D. LOCATION (City, town, or county) (State)
G.A. County. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Joseph B. Lock | |
| 25C. FUNERAL DIRECTOR
Joseph B. Lock | | 25D. ADDRESS
1304 N. Con... | | | |

NO 1807

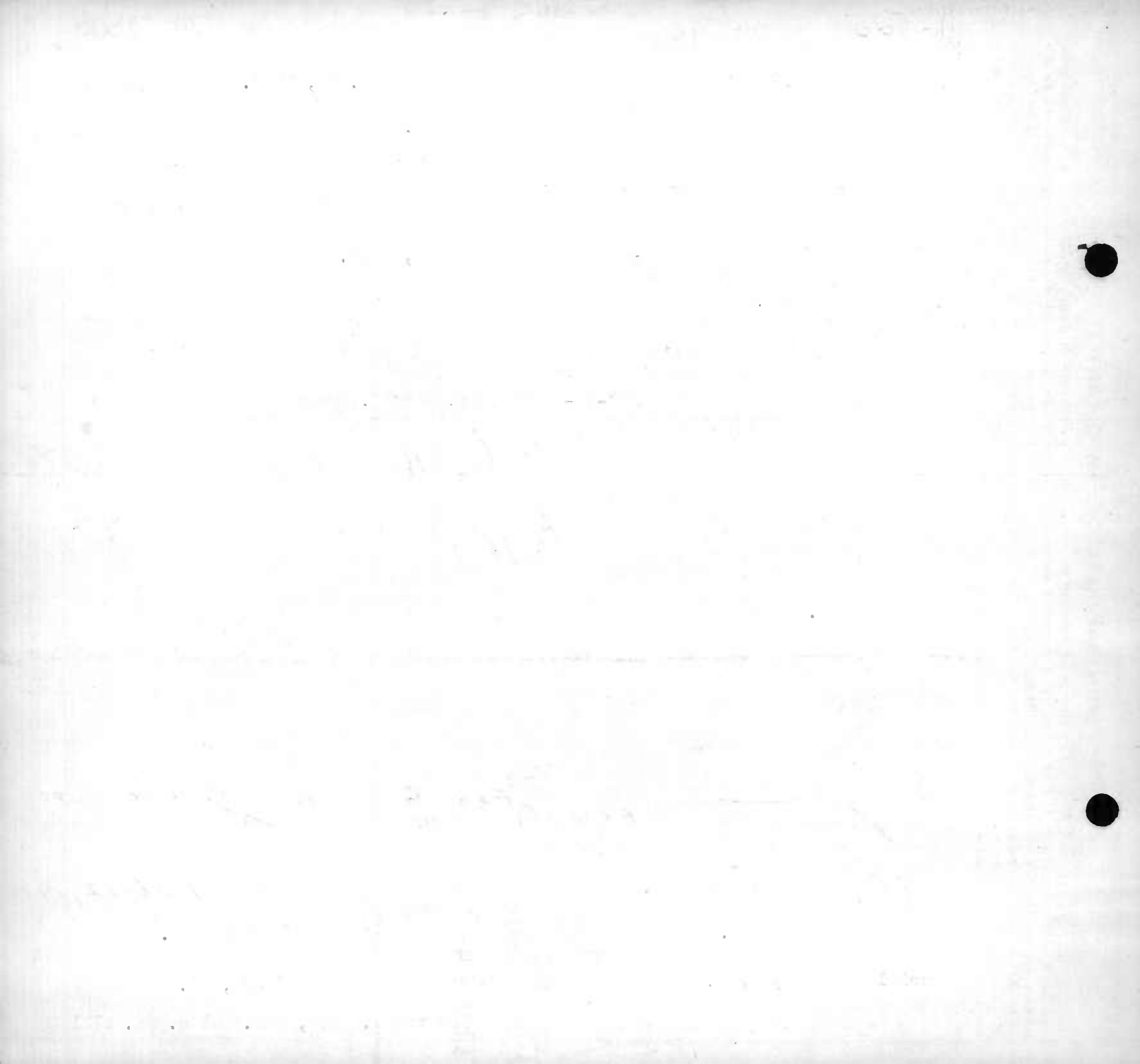
ALICE MARY BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

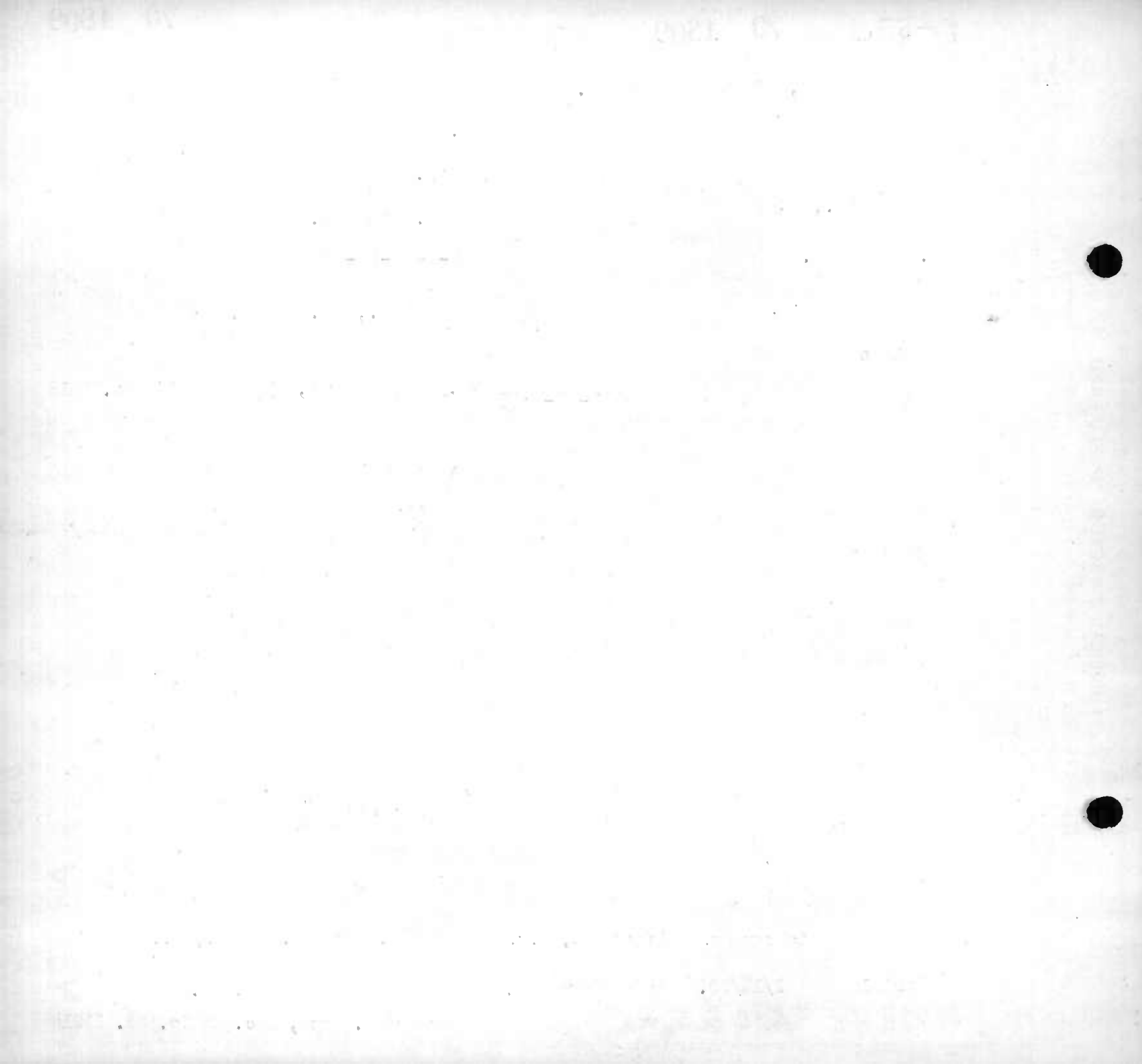
| | | | |
|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1808 | |
| BIRTH NO. 1-525 | | 70 1808 CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) GEORGE HENRY DUNSING | | 2. DATE AND HOUR OF DEATH
Feb. 10, 1970. 2:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
90 House in the Pines (Belvedere) | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 2706 | |
| | | C. CITY OR TOWN
Baltimore | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | E. STREET AND NUMBER
2111 Westfield Avenue | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 26, 1892. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Chauffeur | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 77
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
? Dunsing | | 14. MOTHER'S MAIDEN NAME
? Hiltz | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-10-4893A | 17. INFORMANT
Mrs. Mary E. Brown |
| | | ADDRESS
(Same) | |
| 18. 431.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Coroal Hemorrhage.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hypertension | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C).....
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 months
1 yr. | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION
0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 6 1970 to Feb 10 1970 , that (I) (we) last saw the deceased alive on Feb 9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Alan B. Cohon | | 23B. DATE SIGNED
Feb 12, 1970 | |
| 23C. PHYSICIAN'S NAME (Type)
Alan B. Cohon MD | | 23D. ADDRESS
Marylander Apts. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
2/13/70. | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | 25C. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|---------|--|------------------|--|------------------------------|
| B-530 70 1809 | | 70 1809 | | 70 1809 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Bennett, Miss Florence E. | | 2-11-70 11:25 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| | | MD. | | 1307 | |
| Keswick Home for Incurables of Balto., City | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 91 | | E. STREET AND NUMBER | | 21211 | |
| 700 W. 40th St. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| F. | W. | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | XX- 3-14-25 | 44 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| NONE | | | | Balto., MD. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Tildon Bennett | | Laura Tolson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | C217-01-6633 | | Mrs. Agnes Elfrey, 3512 Ellersie Ave. 21218
Keswick records | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | Kidneys Uremia due to polyesth | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | tardation and Epilepsy Cerebral palsy - left hemiplegia, mental re- | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C)..... | | 1 wk | |
| II | | | | life | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7 July 19 61 to 11 Feb 19 70, that (I) (we) last saw the deceased alive on 11 Feb 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Aubrey Dr. Richardson M.D. | | | | 12 Feb 1970 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Aubrey Dr. Richardson, M.D. | | 700 W. 40th St. Balt., Md. 21211 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/14/70. | | Meadowridge Mem. Cemetery | |
| | | | | Elkridge, Md. | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR ADDRESS | |
| | | Leonard J. Buck, Inc. Balto. Md. 21214 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. 70 1810 | |
|--|--|--|--|--|--|--|--|
| K-656 | | 70 1810 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | EARL O. KORNRUMPF | | February 10, 1970. | | 5 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

90 Harford Gardens Nursing Home | | | | A. STATE

Md. | | B. COUNTY

Caroline | |
| | | | | | | | |
| 5. SEX

Male | | | | 6. RACE

White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| | | | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| Retired Fireman | | | | | | Dec. 17, 1893. | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | 9. AGE (In years last birthday) | |
| Maryland | | | | USA | | 76 | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| George C. Kornrumpf | | | | Frances Scott | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | | | ADDRESS
Mrs. Ruth Edwards, 3804 Frankford Ave. Balto. Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| 19. DATE OF OPERATION | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (APPROX.) | | | |
| 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 15 Nov 1967 to 16 Feb 1970, that (I) (we) last saw the deceased alive on 3 Feb 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE

Howard Goodman | | | | 23B. DATE SIGNED

12 Feb 70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Howard Goodman M.D. | | | | 8604 Harford Rd. Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| Burial | | | | 2/14/70. | | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Greensboro Cemetery | | | | Greensboro, Md. | | | |
| 25A. DATE RECD BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| FEB 16 1970 | | | | Leonard J. Ruck, Inc. Balto. Md. 21214 | | | |

27-10-1942

14

14

14

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1811 | | 70 1811 | |
|---|---------------------|--|------------------------------------|---|---|--|--|
| BIRTH NO.
0-650 | | 70 1811 | | CERTIFICATE OF DEATH | | X REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) <i>George Orem, Jr.</i> | | | | 2. DATE AND HOUR OF DEATH
<i>2-11-70 8:45 P.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>Bolton Hill Nursing Home</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN <i>Reisterstown</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <i>Box 75 Falls Road</i> | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<i>5-11-08</i> | 9. AGE (in years last birthday)
<i>61</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Never Worked</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>George Orem, Sr.</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Nettie Broll</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>216-12-0526</i> | | 17. INFORMANT
<i>Mrs. Nettie Adams</i> | | ADDRESS
<i>(Same)</i> | |
| 18. <i>144 X I</i> CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION <i>0</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

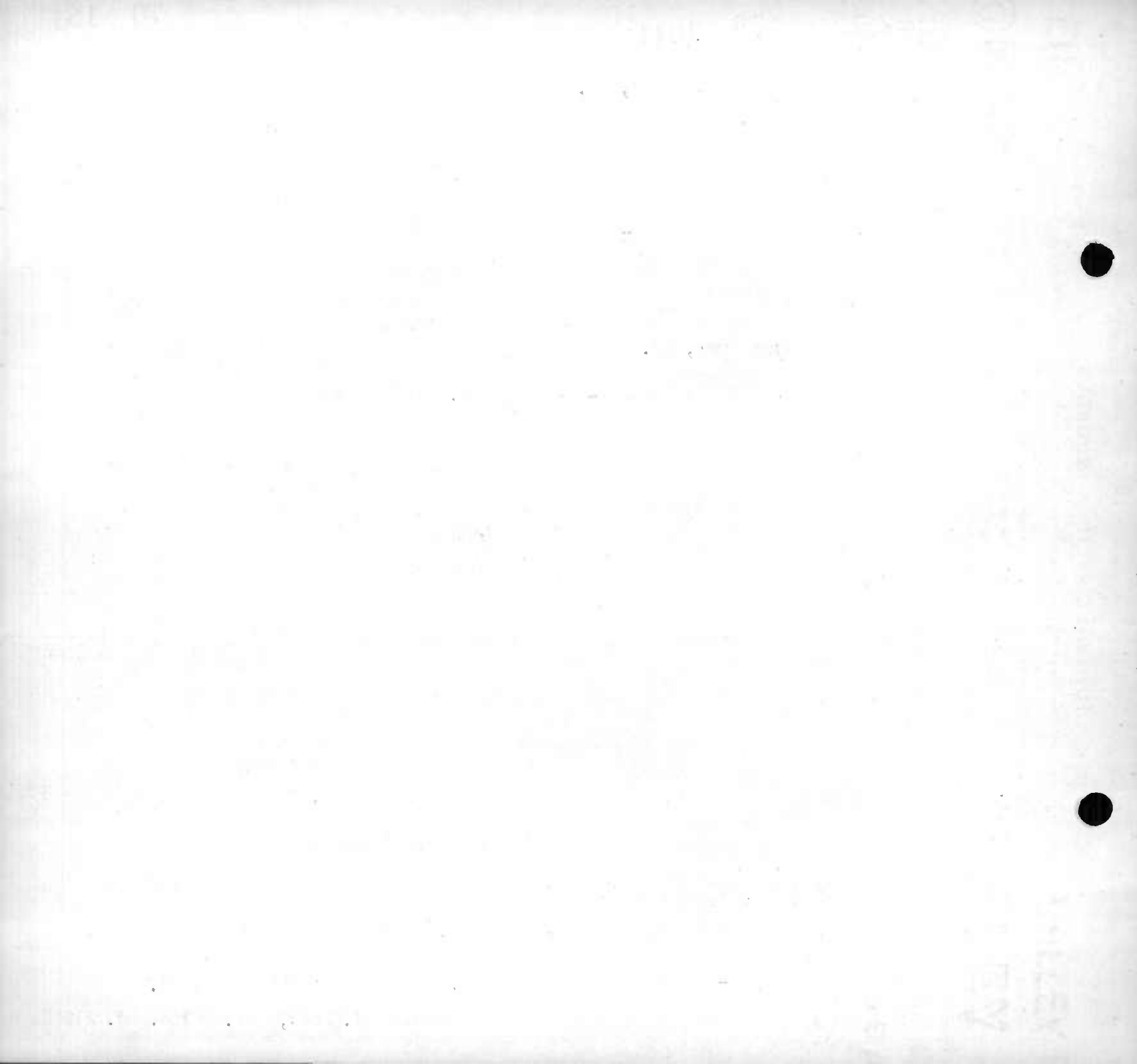
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> At Work
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from <i>2/5</i> 19 <i>70</i> to <i>2/11</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>2/11</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE <i>ALAN H. MAHT MD</i> DEGREE <i>MD</i> 23B. DATE SIGNED <i>2/11/70</i>
Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <i>ALAN H. MAHT MD</i> DEGREE <i>MD</i> 23D. ADDRESS <i>2 E Real St Baltimore 21202</i>

24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> 24B. DATE <i>2/13-70</i> 24C. NAME of CEMETERY or CREMATORY <i>Franklinville Presby. Cemetery</i> 24D. LOCATION (City, town, or county) (State) <i>Franklinville, Md.</i>

25A. DATE REC'D BY HEALTH DEPT. <i>FEB 16 1970</i> 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i> ADDRESS <i>Balto. Md. 21214</i> | | | | | | | |

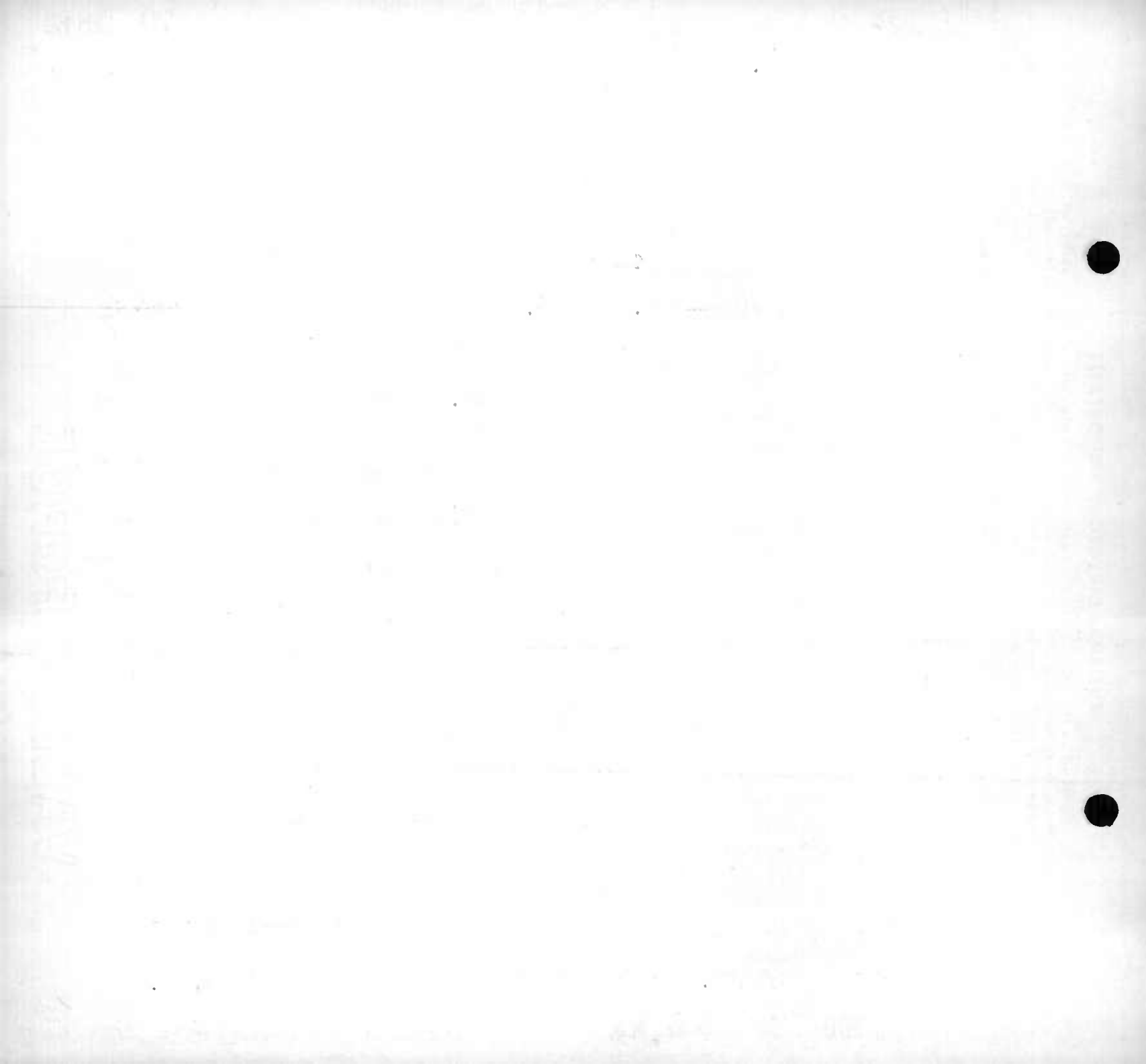


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 70 1812 | | | | |
| BIRTH NO. P-256
M.E. CASE NO. 70 1812
1. NAME OF DECEASED
(Type or Print) Joseph A. Pachmayr | | | | | 2. DATE AND HOUR OF DEATH
2/12/70 1 25 A M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

<div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION
 Maryland General Hosp </div> <div> (If not in hospital or institution, give street address or location)
 </div> </div> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
<div style="display: flex; justify-content: space-between;"> <div> A. STATE
 Md </div> <div> B. COUNTY
 2745 </div> </div> | | | | |
| 5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | | | 8. DATE OF BIRTH 4/7/15 9. AGE (In years last birthday) 54 | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Police | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Beth. Steel Co. | | | | |
| 11. BIRTHPLACE (State or foreign country)
Md. Maryland | | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 13. FATHER'S NAME
John Pachmayr | | | | | 14. MOTHER'S MAIDEN NAME
Isabelle Janssens | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | |
| 17. INFORMANT
Mrs. Berdette Pachmayr | | | | | ADDRESS
(Same) | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Int. obstruction
DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 day | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) Widespread G.
DUE TO | | | | | 2 yrs. | | | | |
| (C) Ca of Rect. Sigmoid
DUE TO | | | | | 7 yrs | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
01967 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
G of Colon | | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (N) (this hospital) attended the deceased from 2/12 19 70 to 2/12 19 70 , that (H) (we) last saw the deceased alive on 2/11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Dewitt Kemp | | | | | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
2/12/70 | |
| 23C. PHYSICIAN'S NAME (Type)
Dewitt Kemp | | | | | | 23D. ADDRESS
Maryland General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70. | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | | 25B. NAME OF REGISTRAR
Robert E. Taber, M.D. | | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruch Inc 1000 Jones | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

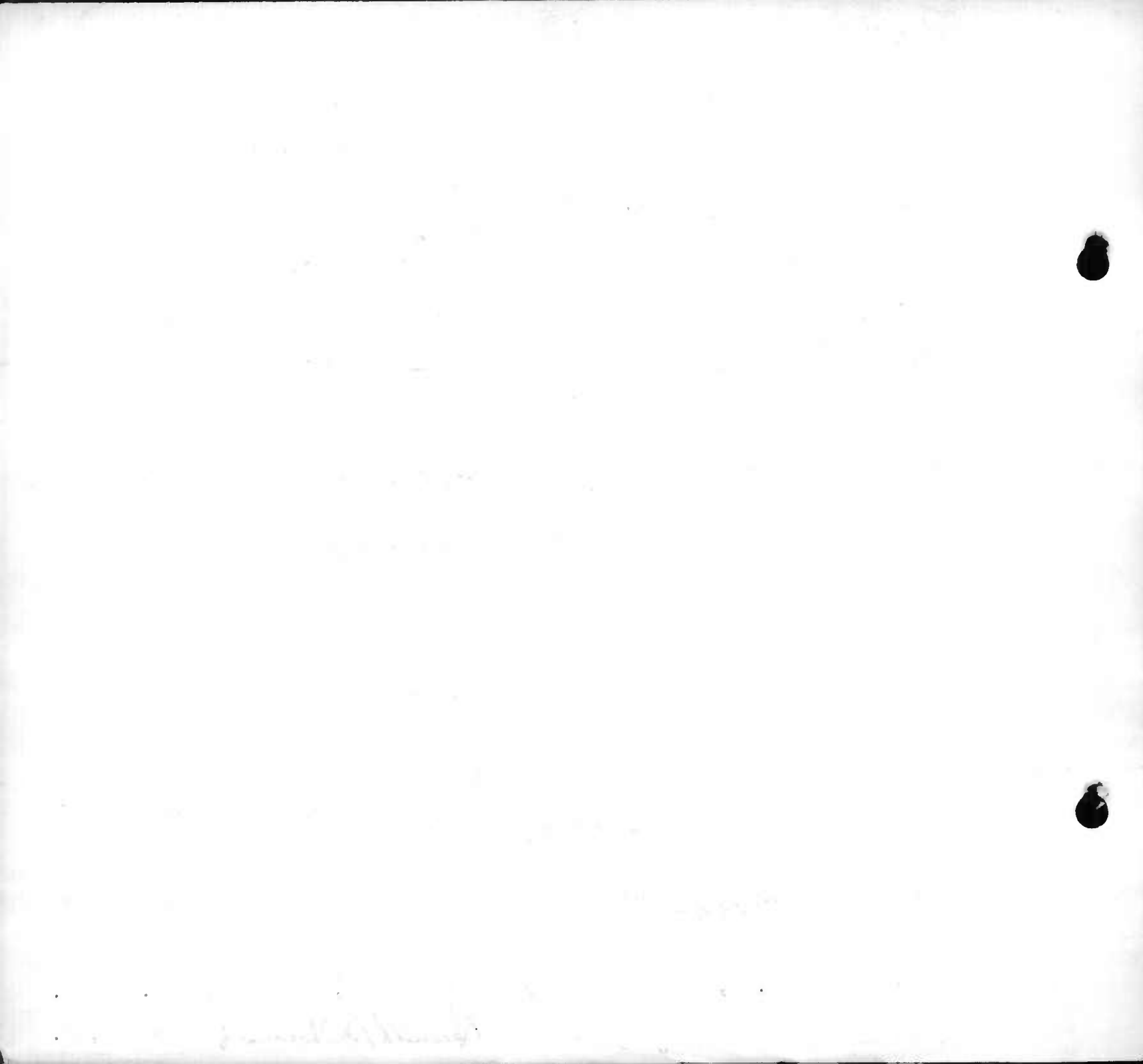
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 70 1813 |
|---|----------------------------------|---|-----------------------------------|---|
| BIRTH NO. 13-652 70 1813 | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Matilda Elizabeth Brannock</u> | | 2. DATE AND HOUR OF DEATH
<u>2/11/70</u> <u>1525</u> P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>Dorchester</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>University Hosp.</u> | | C. CITY OR TOWN
<u>Cambridge</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| E. STREET AND NUMBER
<u>38 Apt 113 Garden Lane</u> | | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>5/6/92</u> | 9. AGE (In years last birthday)
<u>77</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>R.N., Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State, or foreign country)
<u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY
<u>USA</u> | | | | |
| 13. FATHER'S NAME
<u>Solomon Willey</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sally Bradley</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>217-20-8976</u> | | 17. INFORMANT
<u>Hosp. chart.</u> |
| 18. <u>410.91</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>Cerebral Embolus</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 hrs.</u> | | |
| 19. <u>Acute myocardial infarction</u>
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 days.</u> | | |
| 20. <u>Arteriosclerotic cardiovascular dis</u> | | | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> 19 <u>70</u> to <u>2/11</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/11</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Hubert T. Gunley MD</u> | | 23B. DATE SIGNED
<u>2/11/70</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Hubert T. Gunley MD</u> | | 23D. ADDRESS
<u>1921 Greenberry Rd. Balto, Md. 21209</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>Feb. 14, '70</u> | 24C. NAME OF CEMETERY OR CREMATORY
<u>Dorchester Memorial Park, Cambridge, Dorchester, Md.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Cambridge, Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 16 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Farley MD</u> | | 25C. FUNERAL DIRECTOR
<u>Robert A. Thomas</u> |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1814 | |
|--|--|---|---|--|--------------------------------------|
| P-623
70 1814
CERTIFICATE OF DEATH | | BIRTH NO.
70 1814 | | | |
| 1. NAME OF DECEASED
<small>(Type or Print)</small>
DORIS MAY PRITCHETT | | | 2. DATE AND HOUR OF DEATH
11 February 1970 1:50 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

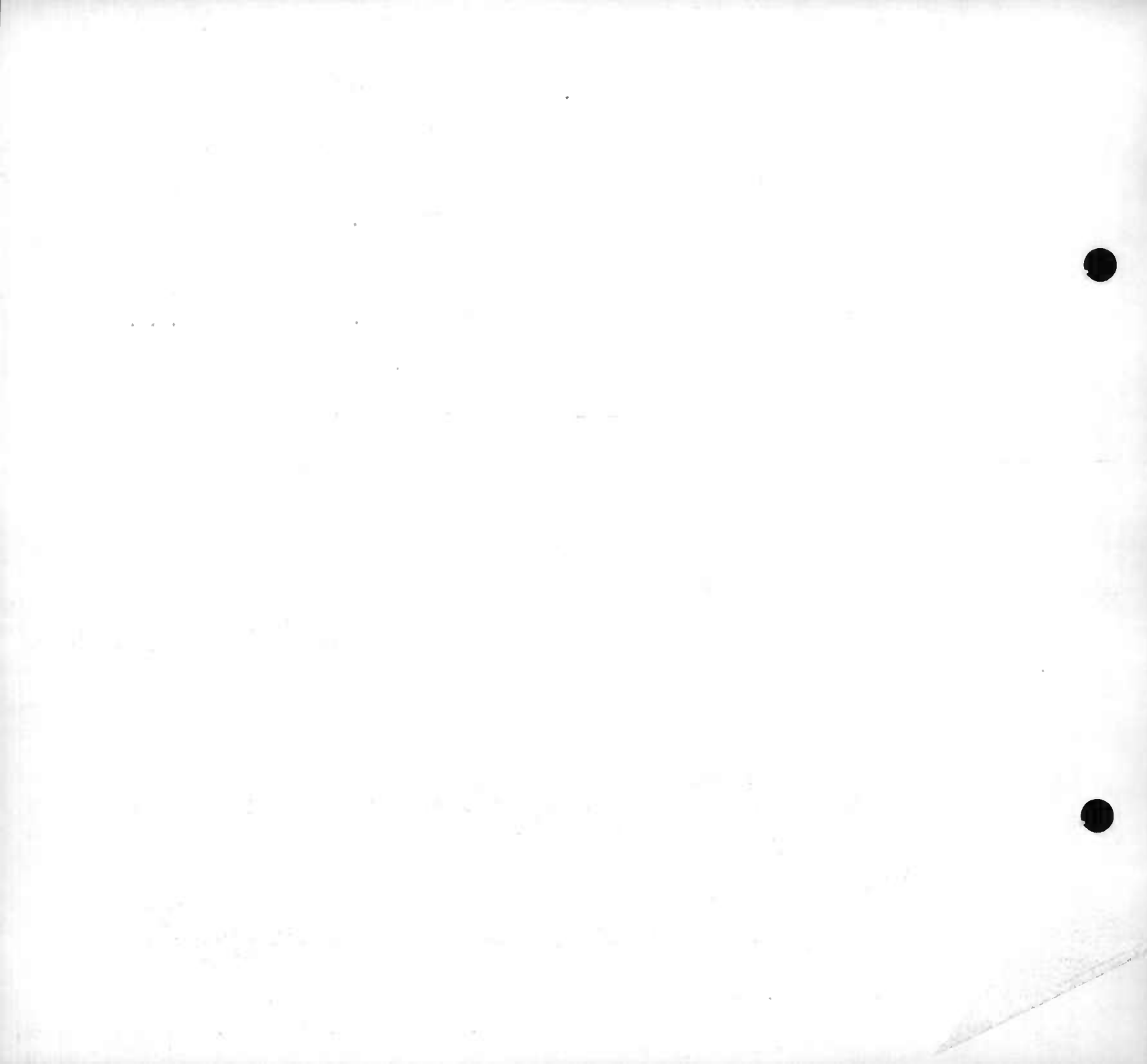
FULL NAME OF HOSPITAL OR INSTITUTION
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION
University of Maryland Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission)
A. STATE
B. COUNTY
MD Dorchester
5913
C. CITY OR TOWN
Cambridge
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER
116 High Street | | |
| 5. SEX
M | | 6. RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
5/27/54 | | 9. AGE (In years last birthday)
15 | | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | | 10B. KIND OF BUSINESS OR INDUSTRY
MD. | | |
| 11. BIRTHPLACE (State or foreign country)
MD. | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Marshall Pritchett | | | 14. MOTHER'S MAIDEN NAME
Delores Pink | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Chart |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
I
5-7-9-1
Hepatic Gna
Chronic Active Hepatitis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hrs - 72 hrs
3 mos. | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9 February 1970 to 11 February 1970 that (I) (we) last saw the deceased alive on 11 February 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Mark M. Dwyer, MD | | | | 23B. DATE SIGNED
11 February 1970 | |
| 23C. PHYSICIAN'S NAME (Type)
Mark M. Dwyer, MD | | | | 23D. ADDRESS
University of Maryland Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Feb. 14, 1970 | | 24C. NAME of CEMETERY or CREMATORY
Dorchester Memorial Park, Cambridge, Dor. Md. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | | |
| 25B. NAME OF REGISTRAR
Robert F. Taylor | | 25C. FUNERAL DIRECTOR
Robert A. Thomas | | | |
| 25D. ADDRESS
Cambridge, Md. | | 25E. ADDRESS
Cambridge, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

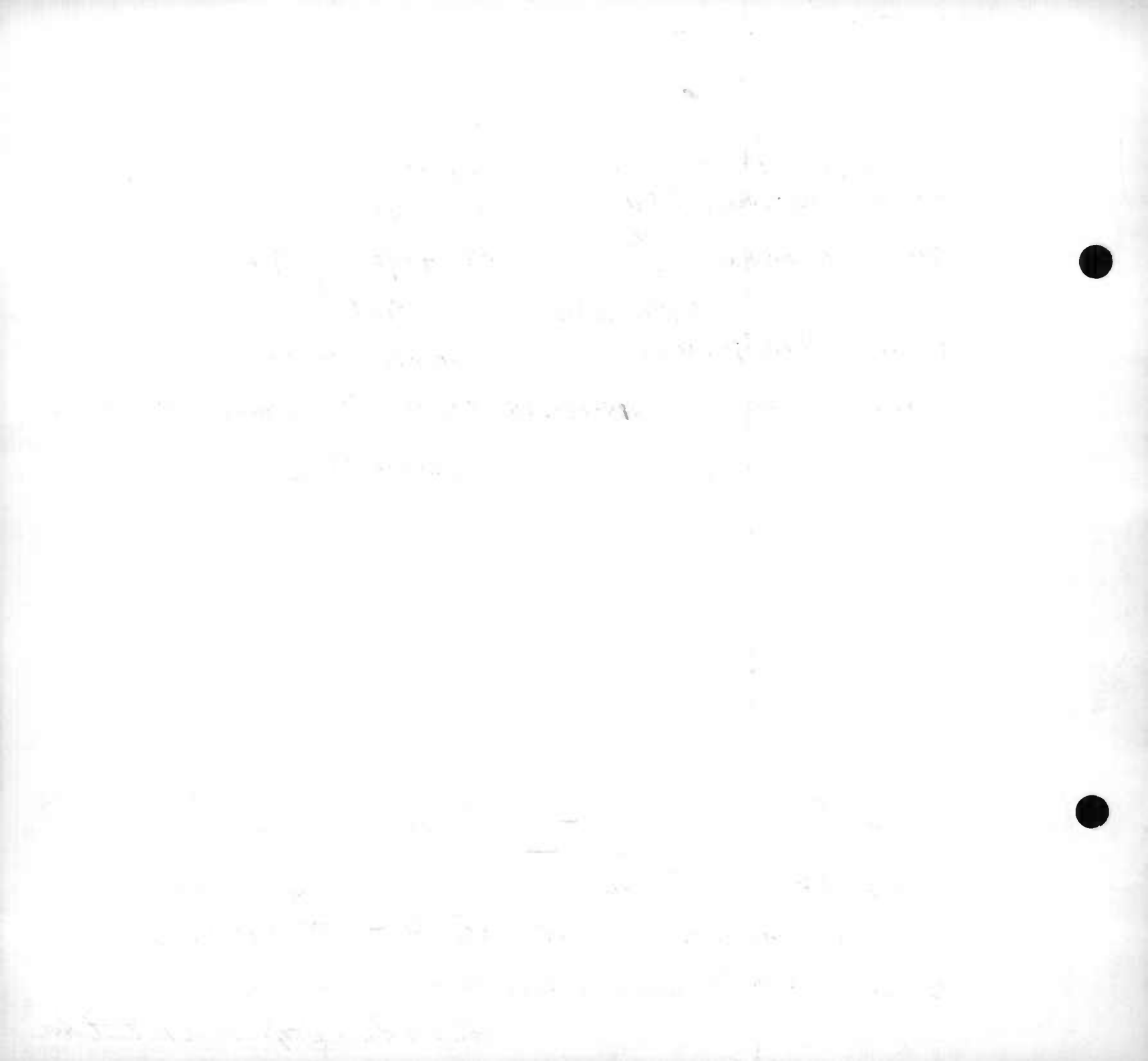
| Baltimore City Health Department | | | | REG. NO. | |
|--|--------------|---|-----------------------------|---|--|
| F-650 | | 70 1815 | | 70 1815 | |
| BIRTH NO. | | 70 1815 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) FROMM MARY J. | | 2. DATE AND HOUR OF DEATH
2/10/70 5:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
3 Bm Seavers Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY
5160 Balto National Pike 5300
C. CITY OR TOWN D. INSIDE CITY LIMITS?
Balto MD YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER
5160 Balto. National Pike | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/01/82 | 9. AGE (In years last birthday)
87 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Lancaster, Pa. | |
| 13. FATHER'S NAME
Frederick Stegman | | 14. MOTHER'S MAIDEN NAME
Anna B. Birkmeyer | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
220-44-8001 | | 17. INFORMANT
Mrs. Mildred G. Kratz | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
CHF, Hydronphuri @ Kidney GI Ulcer | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Acute Myocardial Infarction?
ASHAD
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/27/70 19 to 2/10/70 19
that (I) (we) last saw the deceased alive on 2/9/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. B. RAM | | 23B. DATE SIGNED
2/10/70 | | 23C. PHYSICIAN'S NAME (Type)
J. B. RAM M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Feb. 13, 70 | | 24C. NAME of CEMETERY or CREMATORY
New Cathedral Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
G. Truman Schwab, 5151 Balto. Natl. Pike, Baltimore, Maryland, 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

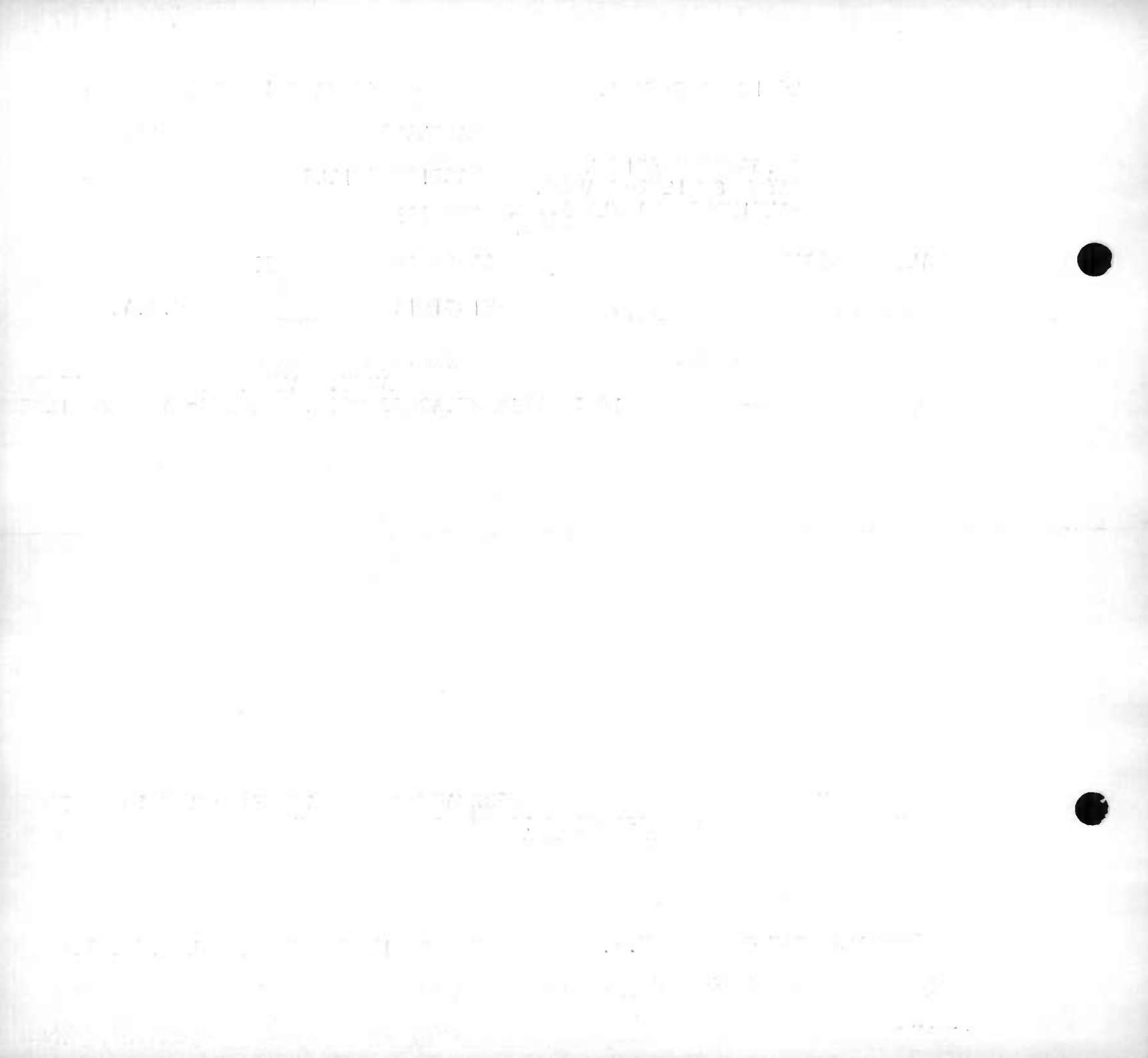
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1816</u> | |
|--|-----------------------------|---|-------------------------------------|--|---|
| M-532 70 1816 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>WILLIAM T. Montgomery</u> | | 2. DATE AND HOUR OF DEATH
<u>2/11/70 8:00 pm</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>1306</u> | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNION MEMORIAL HOSPITAL</u>
<u>382 Street Baltimore Md</u> | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>3532 Reswick Rd</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>08-14-93</u> | 9. AGE (In years last birthday)
<u>76</u> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Textile Mills</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Ind.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
<u>William Montgomery</u> | | 14. MOTHER'S MAIDEN NAME
<u>Anna Foster</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>unknown</u> | | 16. SOCIAL SECURITY NO.
<u>015-07-6538</u> | | 17. INFORMANT
<u>Day sy H. Montgomery</u> ADDRESS <u>the same</u> | |
| 18. <u>410.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>acute M.I.</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>W</u> (this hospital) attended the deceased from <u>1-19</u> 19 <u>70</u> to <u>2-11</u> 19 <u>70</u> that (I) <u>W</u> last saw the deceased alive on <u>2-11</u> 19 <u>70</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) (W) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Dr. van KAMMEN</u> M.D. | | 23B. DATE SIGNED
<u>2/11/70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>DR. VAN KAMMEN</u> M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2-16-70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Moreland Mem. Park</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Balto Co.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 16 1970</u> | | 25B. NAME OF REGISTRAR
<u>John E. Taylor M.D.</u> | |
| 25C. FUNERAL DIRECTOR
<u>Paul C. Choudhury</u> | | 25D. ADDRESS
<u>3615 Chestnut Ave.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| L-200 | | 70 1817 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | 70 1817 | |
|--|--|---|--|--|--|--|--|---|--|
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | | | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | | | LEWIS, JOSEPH J. | | | | FEBRUARY 10, 1970 5:05A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MARYLAND 21229 | | | | A. STATE
MARYLAND | | | | B. COUNTY
Howard 21104 6300 | |
| | | | | C. CITY OR TOWN
MARIOTTSTVILLE | | | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
BOX 133 | | | | | |
| 5. SEX
MALE | | 6. RACE
NEGRO | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11 18 12 | | 9. AGE (In years last birthday)
57 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Janitor | | 10B. KIND OF BUSINESS OR INDUSTRY
School | | 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Cornelius Lewis | | | | 14. MOTHER'S MAIDEN NAME
Malinda Carter | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
219 10 4832 | | 17. INFORMANT AVE. BALTO. MD. ADDRESS 21229
ST. AGNES HOSP. RECORDS-CATON & WILKENS | | | |
| 18. CAUSE OF DEATH | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE
Subarachnoid Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Pulmonary Tuberculosis
DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C)..... | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 9 19 70 to FEBRUARY 10 19 70
that (I) (we) last saw the deceased alive on FEBRUARY 10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Romualdo F. Dator M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
2-10-70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
ROMUALDO DATOR | | | | 23D. ADDRESS
M.D. CATON & WILKENS AVES. BALTO. MD. 21229 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
2-13-70 | | 24C. NAME of CEMETERY or CREMATORY
West Liberty Cemetery | | 24D. LOCATION (City, town, or county) (State)
Howard Co. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR
Robert H. Taylor | | 25C. FUNERAL DIRECTOR
Harry W. Haight | | ADDRESS
Lydellville, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|---|---|---|---|---|--|--|--|
| 70 1818 CERTIFICATE OF DEATH | | | | | X REG. NO. 70 1818 | | | | |
| BIRTH NO. <u>5-300</u> | | | | | 1. NAME OF DECEASED
(Type or Print) <u>WALTER SCOTT</u> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>3400 Secours Hospital</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>2/12/70</u> <u>12:15</u> PM M.
A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u>
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <u>1362 Poplar Avenue.</u> | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4-22-01</u> | 9. AGE (In years last birthday)
<u>68</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Carpenter</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> |
| 13. FATHER'S NAME
<u>Samuel N. Scott</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Berlette</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>UNKNOWN NO</u> | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
<u>CHART</u> | | | | ADDRESS | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>410.9 I</u>
<u>Acute M.I.</u>
<u>Ruptured coronary occlusion</u> | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 days</u>
<u>6 days</u> | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 8</u> 19 <u>70</u> to <u>2/12</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/12</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>Dionisio Garcia Jr. M.D.</u> | | | | 23B. DATE SIGNED
<u>2/12/70</u> | | | 23C. PHYSICIAN'S NAME (Type)
<u>DIONISIO GARCIA JR.</u> | | |
| 23D. ADDRESS
<u>Secours Hospital</u> | | | | 24. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | | |
| 24B. DATE
<u>2/16/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Lorraine Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 16 1970</u> | | | |
| 25B. NAME OF REGISTRAR
<u>R. E. Taylor, R.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Antonia L. 328 Sulphur Sp. Rd.</u> | | ADDRESS | | | | | |

1/10/75

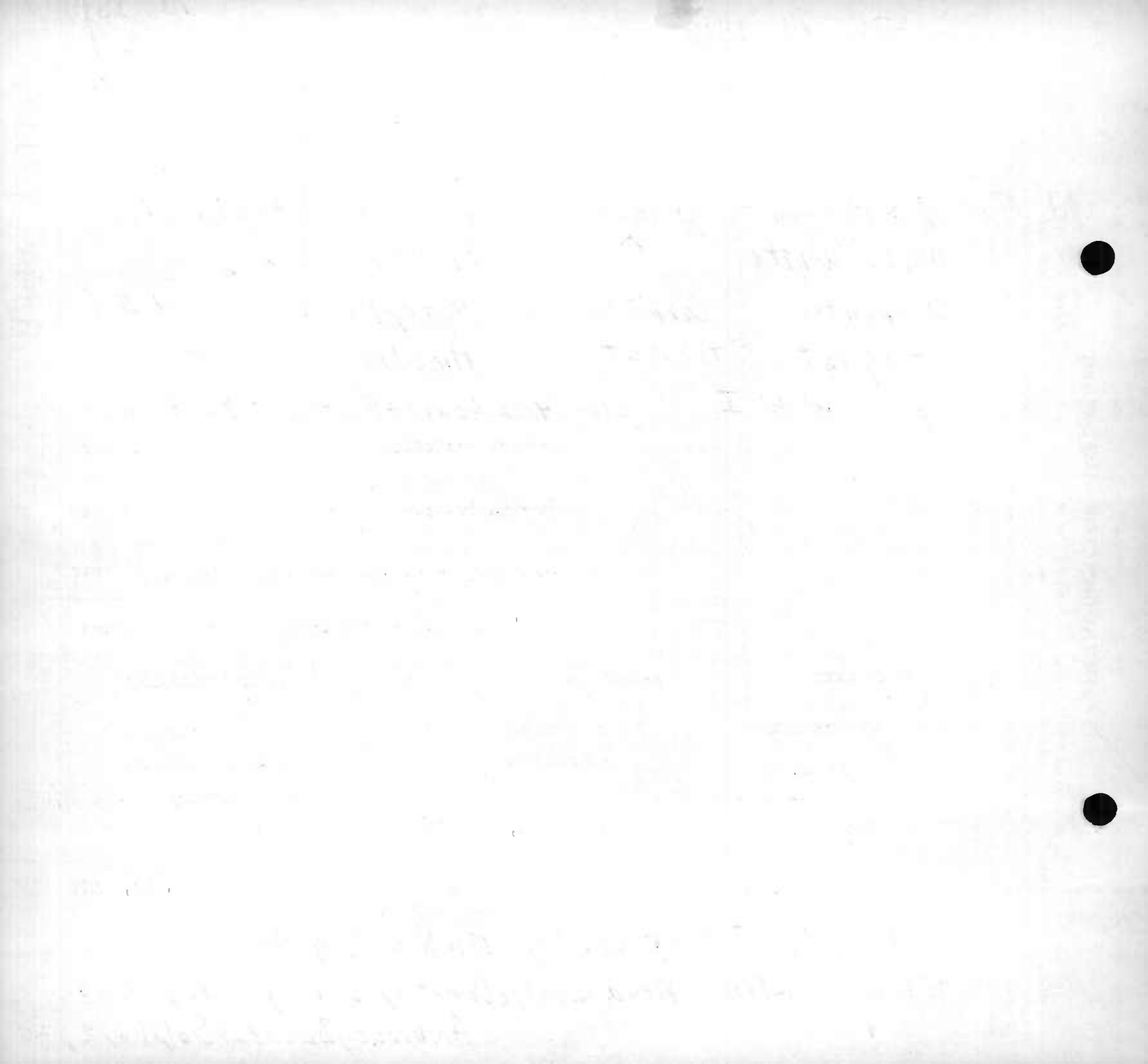
1/10/75

1/10/75
1/10/75
1/10/75

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---|--|--|
| <p>S-365 70 1819</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p> | | <p>REG. NO. 1819</p> | |
| <p>BIRTH NO.</p> <p>1. NAME OF DECEASED
(Type or Print) Charles E. Sternet</p> | | <p>2. DATE AND HOUR OF DEATH
2/11/70 9:00A M.</p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
95 Beechfield Ave</p> | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 2864
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 95 Beechfield Ave.</p> | |
| <p>5. SEX Male</p> | <p>6. RACE White</p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH 8/30/93</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY
Cabinet Maker</p> | <p>11. BIRTHPLACE (State or foreign country)
Maryland</p> |
| <p>13. FATHER'S NAME
August Sternet</p> | | <p>14. MOTHER'S MAIDEN NAME
Amelia Gardner</p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes W.W.I</p> | <p>16. SOCIAL SECURITY NO.
216054322</p> | <p>17. INFORMANT ADDRESS
Louisa M. Sternet 95 Beechfield Ave</p> | |
| <p>18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Coronary occlusion</p> <p>II. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost,
Paget's disease of the bone</p> | | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hour
10 year
10 year
3 years</p> | |
| <p>19A. DATE OF OPERATION XXXXXXXXXX 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED XXXXXXXXXX 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? XXXXXXXXXXXXXXXXXXXX</p> | | | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH XXXXXXXXXX</p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) XXXXXXXXXX</p> | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) XXXXXXXXXX</p> | | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
XXXXXXXXXXXXXXXXXXXX</p> | | <p>21F. HOW DID INJURY OCCUR?
XXXXXXXXXXXXXXXXXXXX</p> | |
| <p>22. I certify that (I) XXXXXXXXXX attended the deceased from 19 65 to January 1970, that (I) xxx last saw the deceased alive on December 2, 1969 and that in (my) xxx opinion death occurred on the date and hour and from the causes stated above. (I) xxx (did) XXXXXX view the body after death.</p> | | | |
| <p>23A. SIGNATURE
Millard T. Trauband Jr.</p> | | <p>23B. DATE SIGNED
Feb. 13, 1970</p> | |
| <p>23C. PHYSICIAN'S NAME (Type)
Dr. Millard T. Trauband Jr.</p> | | <p>23D. ADDRESS
1811 N. Rolling Rd.</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)
Burial</p> | <p>24B. DATE
2/14/70</p> | <p>24C. NAME OF CEMETERY or CREMATORY
Meadowridge Cemetery</p> | <p>24D. LOCATION (City, town, or county) (State)
Dorsey, Maryland</p> |
| <p>25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970</p> | | <p>25B. NAME OF REGISTRAR
xxxxxx</p> | |
| <p>25C. FUNERAL DIRECTOR
Ambrose J. Inc.</p> | | <p>ADDRESS
1328 Sulphur Sp. Rd.</p> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|-------------------------------------|---|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 70 1820 | | 70 1820 | |
| BIRTH NO. D-125 | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) PHILIP DUPKIN | | 2. DATE AND HOUR OF DEATH
2/11/70 11:36 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL HOSPITAL
33RD CALVERT ST. BAL MD | | A. STATE
MD. | | B. COUNTY
2730 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
7121 VANK HIGHTS AVE., PAT. 701 | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/23/94 | 9. AGE (In years last birthday)
75 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY
BUSINESS EXECUTIVE | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
MANUEL DUPKIN | | | |
| 14. MOTHER'S MAIDEN NAME
LENA ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES W.W. I ARMY | | | |
| 16. SOCIAL SECURITY NO.
217-26-5134 | | 17. INFORMANT
MRS. FREDRICKA DUPKIN, 7121 PK. HIGHTS AVE. #15 | | | |
| 18. 428 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
acute myocardial insufficiency | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
D.H. | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/10 19 70 to 2/11 19 70 that (I) (we) last saw the deceased alive on 2/11 19 70 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Donald M. Legum M.D. | | 23B. DATE SIGNED
2/11/70 | | 23C. PHYSICIAN'S NAME (Type)
RONALD M. LEGUM M.D. | |
| 23D. ADDRESS
UNION MEMORIAL HOSPITAL | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | |
| 24B. DATE
2-13-70 | | 24C. NAME OF CEMETERY OR CREMATORY
OHEB SHALOM | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE RECD BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--------------------------------------|---|---|
| P-420 70 1821 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1821 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Tallack, Max</i> | | 2. DATE AND HOUR OF DEATH
<i>525</i> FEBRUARY 11, 1970 | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

PLEASANT MANOR NURSING HOME
4615 PARK HILLS AVE.
BALTIMORE 21210 MD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <i>MD</i> B. COUNTY <i>Balt.</i> | | C. CITY OR TOWN <i>Balt.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
<i>3347 AVONDALE AVENUE</i> | | | |
| 5. SEX
<i>MALE</i> | 6. RACE
<i>WHITE</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>7/15/1892</i> | 9. AGE (In years lost birthday) <i>77</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>SALESMAN</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>FOOD MARKET</i> | | 11. BIRTHPLACE (State or foreign country)
<i>RUSSIA</i> | |
| 13. FATHER'S NAME
<i>UNKNOWN</i> | | 14. MOTHER'S MAIDEN NAME
<i>ANNA ?</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | 16. SOCIAL SECURITY NO.
<i>212-20-0601</i> | | 17. INFORMANT
<i>MRS. SYLVIA SOLOMON, 3408 VARGAS CIRCLE, APT. 2B</i> | |
| 18. <i>4129 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i>
(B) <i>Arteriosclerotic Heart Dis. unknown</i>
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5 minutes</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>01/26/69</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Pacemaker insertion for arrhythmia</i> | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/15</i> 19 <i>70</i> to <i>2/11</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>2/11</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>D. W. STEWART, M.D.</i> | | 23B. DATE SIGNED
<i>2/11/70</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>D. W. STEWART</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>2-13-70</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>SHAAREI ZION</i> | |
| 24D. LOCATION (City, town, or county)
<i>ROSEDALE, MARYLAND</i> | | 25A. DATE RECEIVED BY HEALTH DEPT.
<i>FEB 16 1970</i> | | 25B. NAME of REGISTRAR
<i>Robert E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR
<i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i> | | 25D. ADDRESS | | | |

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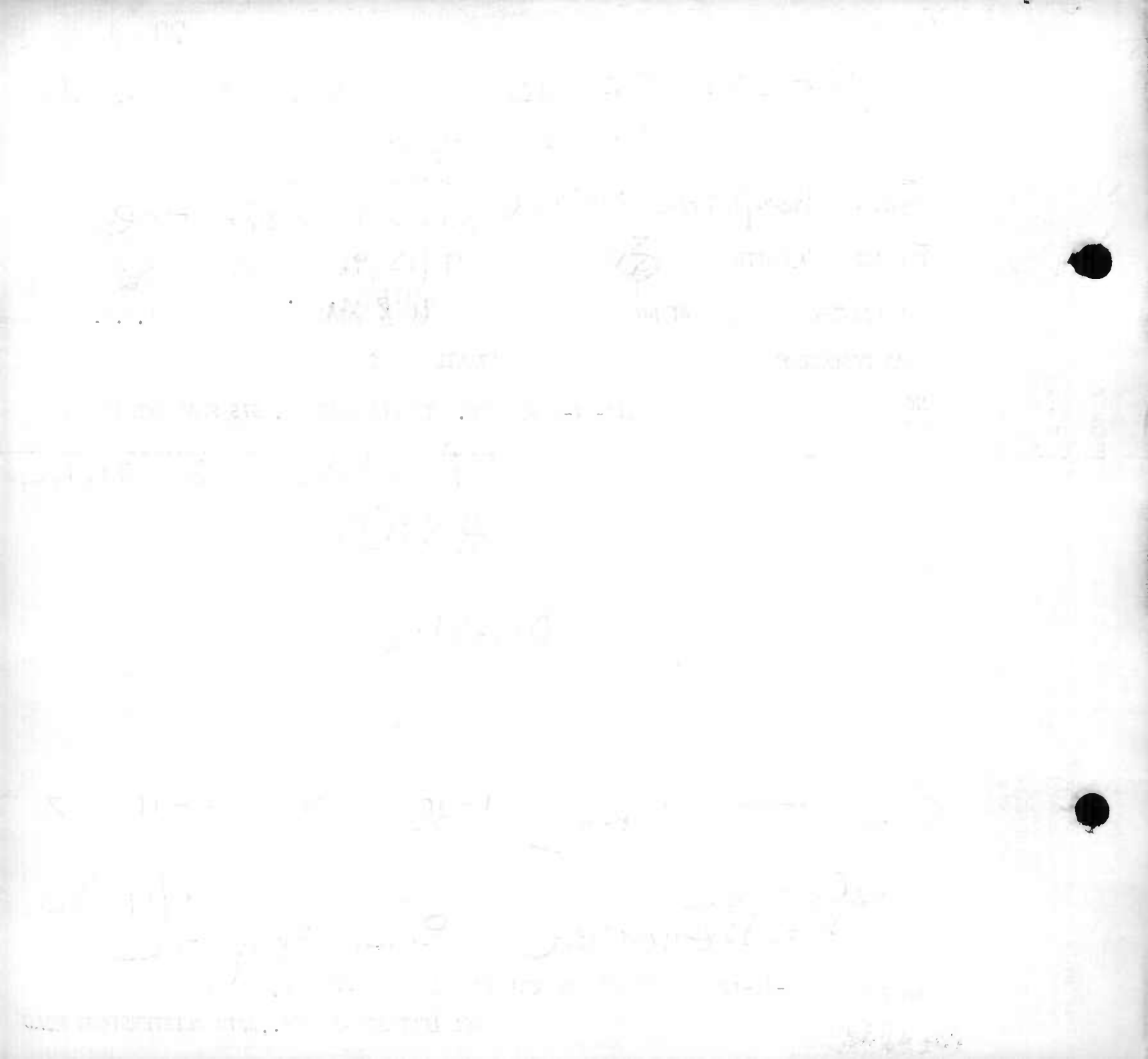
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---|--|--|--|---|
| T-610 70 1822 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1822 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) MATILDA TRAUER | | 2. DATE AND HOUR OF DEATH
2/11/70 4:40 AM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission)
A. STATE MARYLAND B. COUNTY 2719 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
12 SWAN HOSPITAL BALTIMORE | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
5502 MINNOKA AVE | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/12/02 | 9. AGE (In years last birthday)
67 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
MAX ROSENBERG | | | |
| 14. MOTHER'S MAIDEN NAME
MINNIE ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | |
| 16. SOCIAL SECURITY NO.
219-01-3942 | | 17. INFORMANT ADDRESS
MRS. MINDELL KELLMAN, 515 SHAMROCK LANE #8 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
412.301 250.9 | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Acute Pulmonary Edema
(B) ASHD
DUE TO, OR AS A CONSEQUENCE OF:
(C) Diabetes | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hr. | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 21A. DATE OF OPERATION
0 | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 21C. AUTOPSY? (Yes or No) | 21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-10-1970 to 1-11-1970 that (I) (we) last saw the deceased alive on 2-4-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
P B Donovan | | 23B. DATE SIGNED
1/11/70 | | 23C. PHYSICIAN'S NAME (Type)
P B Donovan | |
| 23D. ADDRESS
Swan Hospital | | 23E. DEGREE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 24B. DATE
2-12-70 | 24C. NAME OF CEMETERY OR CREMATORY
MIKRO KODESH BETH ISRAEL | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>70 1823</u> | |
| M-452 70 1823 | | CERTIFICATE OF DEATH | |
| BIRTH NO. <u>M-452</u> | | 1. NAME OF DECEASED (Type or Print) <u>MYER MELNICOVE</u> | |
| 2. DATE AND HOUR OF DEATH <u>2/10/70 at 9:10p</u> M. | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>2730</u> | | 5. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 6. STREET AND NUMBER <u>1301 PARK Heights Ave</u> | | 7. SEX <u>MALE</u> 8. RACE <u>WHITE</u> 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTOM TAILOR</u> | | 11. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u> | |
| 12. DATE OF BIRTH <u>3-15-89</u> 13. AGE (in years last birthday) <u>80</u> | | 14. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 15. BIRTHPLACE (State or foreign country) <u>Russia</u> | | 16. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 17. FATHER'S NAME <u>JOSEPH MELNICOVE</u> | | 18. MOTHER'S MAIDEN NAME <u>ROSE ?</u> | |
| 19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 20. SOCIAL SECURITY NO. | |
| 21. INFORMANT <u>MRS. GERTRUDE MELNICOVE, 7301 PARK HGHTS. AVE.</u> | | ADDRESS | |
| 18. I <u>4189</u> I <u>1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Myocardial Infarction</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASHD</u> | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>-</u> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) <u>-</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> 19 <u>70</u> to <u>2/10</u> 19 <u>70</u> that (I) (we) lost saw the deceased alive on <u>2/10</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>PB Donovan</u> DEGREE | | 23B. DATE SIGNED <u>2/10/70</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>PB DONOVAN MD</u> DEGREE | | 23D. ADDRESS <u>Sinai Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-12-70</u> | |
| 24C. NAME of CEMETERY or CREMATORY <u>AITZ CHAIM</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 16 1970</u> | | 25B. NAME OF REGISTRAR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | 70 1824 | |
|---|-------------------------|---|--|---|--|
| W-140 70 1824 | | | | 70 1824 | |
| BIRTH NO. | | | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) MARIE O. WHIPPLE | | | | 2. DATE AND HOUR OF DEATH
2-13-70 5:15 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
MARYLAND GENERAL HOSPITAL | | | | A. STATE
3608 HILLSDALE RD 2841 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
BALTIMORE | |
| | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
BALTIMORE COUNTY, MARYLAND | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/9/94 | 9. AGE (In years last birthday)
75 | If Under 1 Yr. Months Days If Under 1 Yr. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country)
BALTIMORE | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | |
| 13. FATHER'S NAME
THOMAS DIVEN | | | 14. MOTHER'S MAIDEN NAME
IDA ZIMMERMAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
25-03-3493 | | |
| | | | 17. INFORMANT
Homer L Whipple - Same | | |
| | | | ADDRESS | | |
| 18. 153.8 I | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) IMMEDIATE CAUSE
CARCINOMA COLON
DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) HEPATIC FAILURE.
DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
X NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/11 19 70 to 2/13 19 70 that (I) (we) last saw the deceased alive on 2/13 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Michael G. G... | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
DEGREE | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2-16-70 | | 24C. NAME of CEMETERY or CREMATORY
Lorraine Cemetery | |
| 24D. LOCATION
BALTIMORE, MD. | | 24E. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 24F. NAME OF REGISTRAR
Robert E. Gable, M.D. | |
| 24G. FUNERAL DIRECTOR
Armacost Funeral Chapel-4600 Liberty Hts | | 24H. ADDRESS | | 24I. STATE | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>70 1825</u> |
|---|--|---|--|---|
| C-240 70 1825 | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>ARLENE S. CAGLE</u> | | 2. DATE AND HOUR OF DEATH
<u>2/12/70 4:15 P.M.</u> |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>1307</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Union Memorial Hospital</u> | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>F</u> 6. RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER
<u>4003 Roland Ave</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Saleslady</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>The Hecht Co.</u> | | 8. DATE OF BIRTH
<u>12/18/22</u> 9. AGE (In years last birthday)
<u>47</u> |
| 11. BIRTHPLACE (State or foreign country)
<u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>John Shields</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lemma Lester</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>237-24-9126</u> | | 17. INFORMANT
<u>Eli L. Cagle - 4003 Roland Ave.</u> |
| 18. <u>244X1</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
<u>Myxedema</u> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) <u>O.Y.</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/28/70</u> to <u>2/12/70</u> that (I) (we) lost saw the deceased alive on <u>2/12/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Ronald V. Geckler, MD.</u> | | 23B. DATE SIGNED
<u>2/12/70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Ronald V. Geckler, MD.</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/16/70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Woodlawn Cemetery</u> |
| 24D. LOCATION
<u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 16 1970</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, R.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Ann Donovan - 3818 Roland Ave.</u> | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1826 | |
|--|--|---|--|--|--|
| H-543 70 1826 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Mary E. Hamilton</i> | | 2. DATE AND HOUR OF DEATH
<i>2-12-70 11:45 A.M.</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>Lutheran Hosp. of Md.
730 Ashburton St.</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>2505</i> | | | |
| 5. SEX <i>F</i> 6. RACE <i>white</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>6-23-1887</i> 9. AGE (In years last birthday) <i>82</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None - Housewife</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore, MD</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 13. FATHER'S NAME <i>Cot</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>212-54-9229</i> | | 17. INFORMANT <i>SON - 113 Round Bay Rd - Severna Park.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Pneumonia</i> | | 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.
<i>Fracture of left femur</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 21. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Fracture of left femur</i> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11-15-1969</i> to <i>2-12-1970</i> , that (I) (we) last saw the deceased alive on <i>2-12-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23. SIGNATURE <i>B. Jalali</i> 23B. DATE SIGNED <i>2-12-70</i> | | | |
| 23A. PHYSICIAN'S NAME (Type) <i>Behnaz Jalali</i> | | 23C. ADDRESS <i>Lutheran Hosp. of Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>2-16-70</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Headwedge Cemetery</i> | |
| 24D. LOCATION (City, town, or county) <i>Elkridge, Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>FEB 16 1970</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Talley</i> | |
| 25C. FUNERAL DIRECTOR <i>J. H. Hahn</i> | | 25D. ADDRESS <i>4200 Pennington Ave.</i> | | 25E. CITY, STATE, ZIP <i>21226</i> | |

Coded to 1012 Brandon Ct.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 70 1827 |
|--|-----------------------------|---|--|---|--|
| J-523 70 1827 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Jessie Johnston</i> | | 2. DATE AND HOUR OF DEATH
<i>2-4-70 4⁴⁵ P.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>90 HILLCREST Nursing Home</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> | |
| | | C. CITY OR TOWN <i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<i>1616 Bolton St.</i> | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>Caucasian</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>1-1-84</i> | 9. AGE (In years last birthday)
<i>86</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Librarian</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Library</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Unknown</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | | |
| 13. FATHER'S NAME
<i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME
<i>UNKNOWN</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>212-03-0935A</i> | | 17. INFORMANT
<i>Mr. Himen Chapel Hill Nursing Home</i> | |
| 18. <i>412.3 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Myocardial ischemia</i> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 23 1969</i> to <i>February 4 1970</i> , that (I) (we) last saw the deceased alive on <i>Feb. 1 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Vicente M. Ruano MD</i> | | 23B. DATE SIGNED
<i>2-4-70</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Vicente M. Ruano MD</i> | | 23D. ADDRESS
<i>1632 Peyster St. Baltimore MD</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>Feb. 12, 1970</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Loudon Park Cemetery</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 16 1970</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher, Jr.</i> | | 25C. FUNERAL DIRECTOR
<i>Loring Byers</i> | |
| | | | | ADDRESS
<i>8728 Liberty Road 21133</i> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| E-256 | | 70 1828 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1828 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) <i>Eisner, ABRAHAM</i> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 2. DATE AND HOUR OF DEATH
<i>2-12-70 12:50P.M.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>90 LEVINDALE and home Baltimore, MD 21218</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>MD</i> B. COUNTY <i>2717</i> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
<i>Balto</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
<i>1887</i> | | 9. AGE (In years last birthday) <i>82</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>Levinale Home Same</i> | |
| 18. <i>440.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>Pulmonary infarction</i>
(B) <i>Arteriosclerosis generalized</i>
(C) _____ | | | |
| 19. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5-4-1960</i> to <i>2-12-1970</i> , that (I) (we) last saw the deceased alive on <i>2-12-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Young Hea Lew</i> DEGREE | | | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Young Hea Lew MD</i> DEGREE | | | | | | 23D. ADDRESS
<i>Levinale home & infirmary</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<i>2/13/70</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Balto Hebrew</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Balto Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 16 1970</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher MD</i> | | 25C. FUNERAL DIRECTOR
<i>Stephen S. Lewis & Son</i> | | ADDRESS
<i>9618 Reisterstown Rd</i> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1829

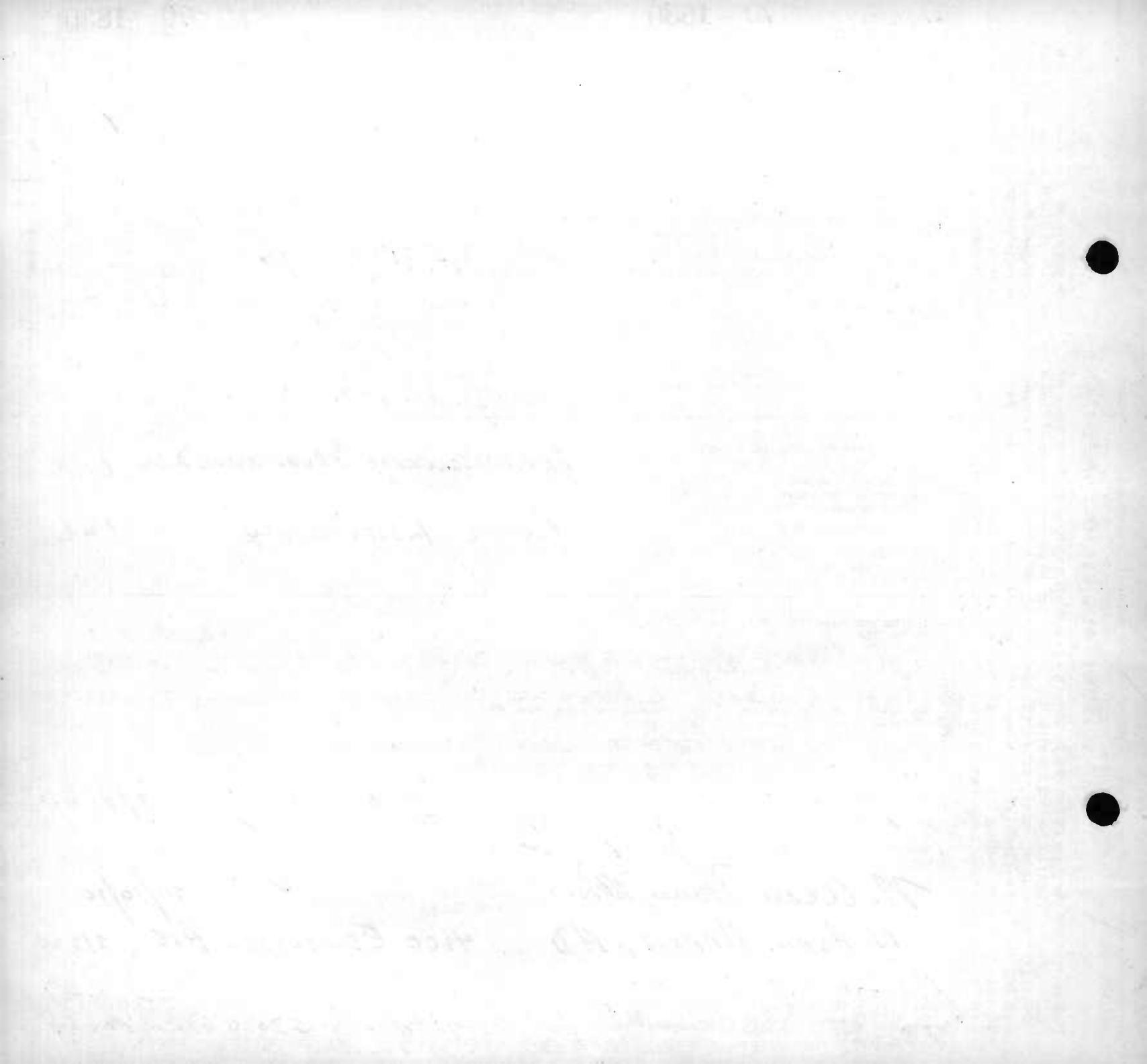
BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) RONALD SPIES | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
2920 N. Calvert Street # 2D | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
February 12, 1970 7:45 A. M. | |
| 6. SEX
Male | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 1202 | |
| 9. DATE OF BIRTH
April, 1, 1944 | | 10. AGE (In years lost birthday) 25
If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF
U.S.A. | |
| 13. FATHER'S NAME
William Francis Spies | | E. STREET AND NUMBER
2920 N. Calvert St. #2D | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 14B. KIND OF BUSINESS OR INDUSTRY
Automobile Bus. | |
| 15. MOTHER'S MAIDEN NAME
Evelyn Grace Holsinger | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO.
215-42-7237 | | 18. INFORMANT
Wm. F. Spies ADDRESS 37 Maybin Circle Owings Mills, Md. | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Early pneumonitis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
Yes | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. | |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED
February 12, 1970 | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | |
| 24B. DATE
Feb. 16, 1970 | | 24C. NAME OF CEMETERY or CREMATORY
Druid Ridge Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Pikesville, Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | |
| 25B. NAME OF REGISTRAR
Robert E. [Signature] | | 25C. FUNERAL DIRECTOR
Eckhardt | |
| ADDRESS
Owings Mills, Md. | | VS 151-REV. 7/1/68 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| A-536 | | 70 1830 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1830 | |
|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) Thomas Anderson | | | | 2. DATE AND HOUR OF DEATH
2-9-70 - - 11:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 1607 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Dukeland Nursing 90 1501 Dukeland ST Baltimore, Md 21216 | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
3/5/91 | | 9. AGE (In years last birthday) 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 11. BIRTHPLACE (State or foreign country)
Johnson Co, N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
218-10-9079 | | 17. INFORMANT ADDRESS
Dukeland Nursing Home | |
| 18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE UNIC | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WK | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) 0 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that at (this hospital) attended the deceased from 1/13 1970 to 2/9 1970 , that at (we) lost saw the deceased alive on 2/9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
N. Alan Harris, M.D. DEGREE
23C. PHYSICIAN'S NAME (Type)
N. Alan Harris, M.D. DEGREE | | | | 23B. DATE SIGNED
2/10/70 | | 23D. ADDRESS
4200 Edmondson Ave 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burned | | 24B. DATE
2/14/70 | | 24C. NAME OF CEMETERY or CREMATORY
ARBUTUS Mm PR | | 24D. LOCATION (City, town, or county) (State)
ARBUTUS BALTIMORE 21227 | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
M. A. Adams 638 N. Gilman St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|--|---------------------------|---|--|---|---|--|---|------------------------------------|---------|
| BIRTH NO. 8-53570 | | 1831 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 | | 1831 | |
| 1. NAME OF DECEASED
(Type or Print) BERTHA SNOWDEN | | | | | 2. DATE AND HOUR OF DEATH
2-10-70 11 P. M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
EDGEWOOD NURSING HOME
6000 BELLONA AVE
BALTIMORE MD 21212 | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY 1901 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
90 | | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| E. STREET AND NUMBER
8 N. BRUCE ST | | | | | | | | | |
| 5. SEX
F | 6. RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-3-1893 | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months: Days: Hours: Min. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | | 10B. KIND OF BUSINESS OR INDUSTRY
Put Family | | 11. BIRTHPLACE (State or foreign country)
A. A. CO MD | | | | |
| 13. FATHER'S NAME
ABRAHAM | | | | | 14. MOTHER'S MAIDEN NAME
Mary Ann | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Agnes Campbell 8 N Bruce St | | | | ADDRESS |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
4/2.1 I | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerotic heart dis.
5+yr | | | | |
| | | | | | (B) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF:
10+yr. | | | | |
| | | | | | (C)..... | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Gunshot wound of head | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48yr. | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 26 1970 to Feb 10 1970 , that (I) (we) last saw the deceased alive on Feb 4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Frederick J. Vollmer MD | | | | | | | | 23B. DATE SIGNED
2-14-70 | |
| 23C. PHYSICIAN'S NAME (Type)
FREDERICK J. VOLLMER MD | | | | 23D. ADDRESS
6100 YORK RD BALTIMORE MD 21212 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
2/14/70 | | 24C. NAME OF CEMETERY OR CREMATORY
MT AUBURN CEMETARY BALTIMORE | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Thomas P. Hyman | | ADDRESS
6387 Johns St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1832 | |
|---|--|---|---|--|---|
| BIRTH NO. 70 1832 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) WALTER GOSCINIAK | | | 2. DATE AND HOUR OF DEATH
2-10-70 9:08 A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 103 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 EDGEWOOD NURSING HOME | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
721 S. LAKEWOOD AVE | | |
| 5. SEX
M. | 6. RACE
W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/22/1886 | 9. AGE (In years last birthday)
83 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CARPENTER | | 10B. KIND OF BUSINESS OR INDUSTRY
B & O | | 11. BIRTHPLACE (State or foreign country)
POLAND | |
| 13. FATHER'S NAME
UNKNOWN | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 14. MOTHER'S MAIDEN NAME
UNKNOWN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
705-03-5134 | | 17. INFORMANT
MR. FRANK GOSCINIAK ADDRESS 2539 FAIR AVE | |
| 18. 41241
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE Cerebral thrombosis
DUE TO, OR AS A CONSEQUENCE OF: 16 days
(B) Arteriosclerosis cardiovascular
DUE TO, OR AS A CONSEQUENCE OF: ? yrs
(C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 25 1970 to Feb 10 1970 that (I) (we) last saw the deceased alive on Feb 8 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Frederick J. Vollmer MD | | | | 23B. DATE SIGNED
2-10-70 | |
| 23C. PHYSICIAN'S NAME (Type)
FREDERICK J. VOLLMER MD | | | | 23D. ADDRESS
6100 YORK RD BALTO MD 21212 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2/14/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Rosary CEMETERY | |
| 24D. LOCATION
BALTIMORE MD. | | 24E. NAME OF REGISTRAR
John E. Kelly, Jr. | | 24F. FUNERAL DIRECTOR
RAYMOND H. KACZIROWSKI | |
| 25A. DATE RECORDED IN HEALTH DEPT.
2-16-1970 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS
2525 FLEET ST | |

Book 1, 1880-1881

1880-1881, 1881-1882

1882

1882

1882

1882-1883

1883-1884

1884

1884-1885

1885

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1833 | |
|--|---------|--|------------------|--|------------------------------|
| BIRTH NO. | | 70 1833 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| WALTER J. GILNER (GIELNER) | | FEBRUARY 10, 1970 1 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| 00 2624 FAIT AVE. | | MARYLAND | | BALTIMORE | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | E. STREET AND NUMBER | | | |
| | | 2624 FAIT AVENUE | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| MALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | JAN. 10 1906 | 64 | U. S. A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RICCER | | BETH. STEEL | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| JOSEPH GILNER | | SOPHIA BANASZAK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 215-07-4161 | | MRS. THEODORA GILNER 2624 FAIT AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Anterior Wall MI - Myocardial Infarction | | | |
| ANTECEDENT CAUSES | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Hypertension C.V.D. - Generalized Atherosclerosis, Coronary Artery Disease | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) Same as Anterior Wall MI | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (the hospital) attended the deceased from Jan 19 50 to Feb 10 19 70, that (I) (we) lost saw the deceased alive on Feb 1, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Michael J. Jaworski, M.D. | | 2/13/70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| M. J. JAWORSKI, M.D. | | 2711 Eastern Ave Balt Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 2/13/70 | | St. Stanislaus Cem. | |
| | | | | BALTIMORE MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 16 1970 | | Robert E. Jabens, M.D. | | RAYMOND H. KACZOROWSKI | |
| | | | | ADDRESS | |
| | | | | 2525 FLEET ST. | |

James and Refining Co.
Refining Co. -
Refining Co. -
Refining Co. -

Refining Co. -
Refining Co. -

Refining Co. -
Refining Co. -

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1834 | |
|---|--|--|---|--|--|
| H-620 70 1834 | | | | REG. NO. | |
| BIRTH NO. | | | 1. NAME OF DECEASED
(Type or Print) HIRSCH MARGARET M. | | |
| 2. DATE AND HOUR OF DEATH
February 11 10:15 AM. | | | M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNIVERSITY OF MARYLAND HOSPITAL | | | A. STATE MD B. COUNTY BALTIMORE | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX Female 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | E. STREET AND NUMBER 4017 Ridge Craft Rd Balto MD 21206 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 8. DATE OF BIRTH 4/23/24 9. AGE (In years last birthday) 45 | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 13. FATHER'S NAME LEWIS SCHMIOT | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 14. MOTHER'S MAIDEN NAME MARGARET ? | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Husband ADDRESS 4017 Ridge Craft Rd | | |
| 18. 182.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE CARCINOMATOSIS
DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (B) Metastatic Ca of the Uterus to Liver - Feb 70
DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) Carcinoma of Uterus - May 1969 - Feb 70 | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | None known | | |
| 19A. DATE OF OPERATION MAY 1969 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA UTERUS | | 20A. AUTOPSY? (Yes or No) N.O. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, lam, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/26 19 70 to 2/11 19 70 that (I) (we) last saw the deceased alive on 2/11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Abraham C. Karas DEGREE | | | | 23B. DATE SIGNED 2/11/70 | |
| 23C. PHYSICIAN'S NAME (Type) ABRAHAM C. KARAS DEGREE | | | | 23D. ADDRESS UN. of MARYLAND HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/14/70 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer | |
| 24D. LOCATION (City, town, or county) Balto Md | | 24E. LOCATION (State) Balto Md | | 24F. LOCATION (Country) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 16 1970 | | 25B. NAME OF REGISTRAR Robert E. Taylor, Md | | 25C. FUNERAL DIRECTOR W. E. Beeman ADDRESS 6067 Hay Rd | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1835</u> | |
|---|------------------|--|------------------------------------|---|--|
| R-208 <u>70</u> 1835 | | 70 1835 | | X | |
| 1. NAME OF DECEASED
(Type or Print) <u>RACH, ERIC</u> | | 2. DATE AND HOUR OF DEATH
<u>Feb 11, 70</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>38 University of Md</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>BALTO. CO</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1734 Edgewood Rd 21234</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 31, 69</u> | 9. AGE (In years last birthday) <u>6 wks</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Balto Md</u> | |
| 13. FATHER'S NAME <u>Paul Rach</u> | | 14. MOTHER'S MAIDEN NAME <u>Regina Grant</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Paul Rach 1734 Edgewood Rd</u> ADDRESS | |
| 18. <u>746.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | (A) IMMEDIATE CAUSE <u>Hypoxia</u> DUE TO, OR AS A CONSEQUENCE OF:

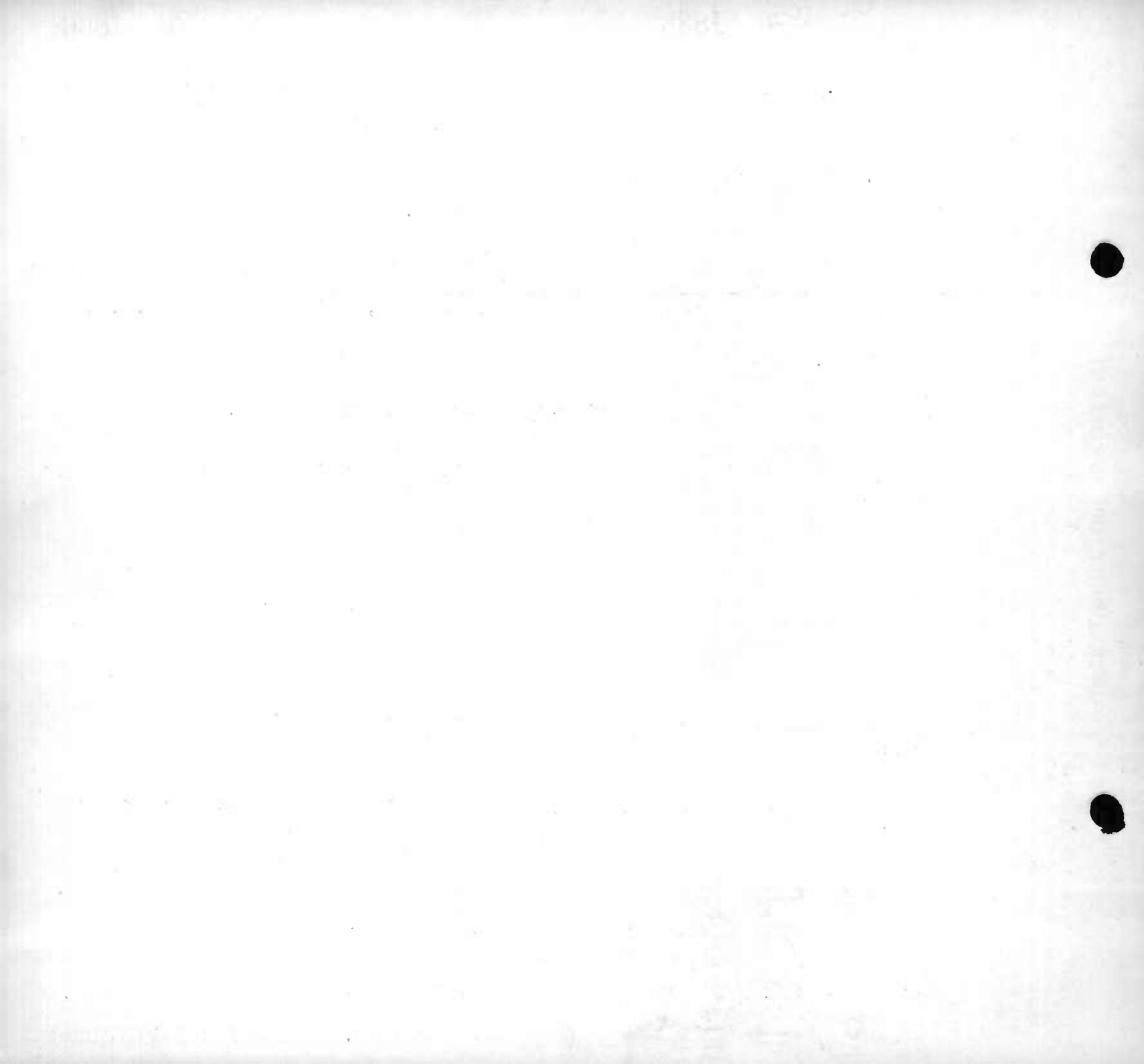
(B) <u>St lung metastatic - pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:

(C) <u>concurrent H-D + congestive failure</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>18 h.</u> | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-10-1970</u> to <u>2-11-1970</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>11 am</u> | | | | | |
| 23A. SIGNATURE <u>Rach</u> | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) <u>K. HAWLA AL-ABBAS</u> | |
| 23D. ADDRESS <u>University Hosp of Maryland</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>2/13/70</u> 24C. NAME of CEMETERY or CREMATORY <u>Immanuel</u> 24D. LOCATION <u>Balto Md</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 16 1970</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Gabley</u> | | 25C. FUNERAL DIRECTOR <u>Off. Seeman 6067 Halford Ave</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

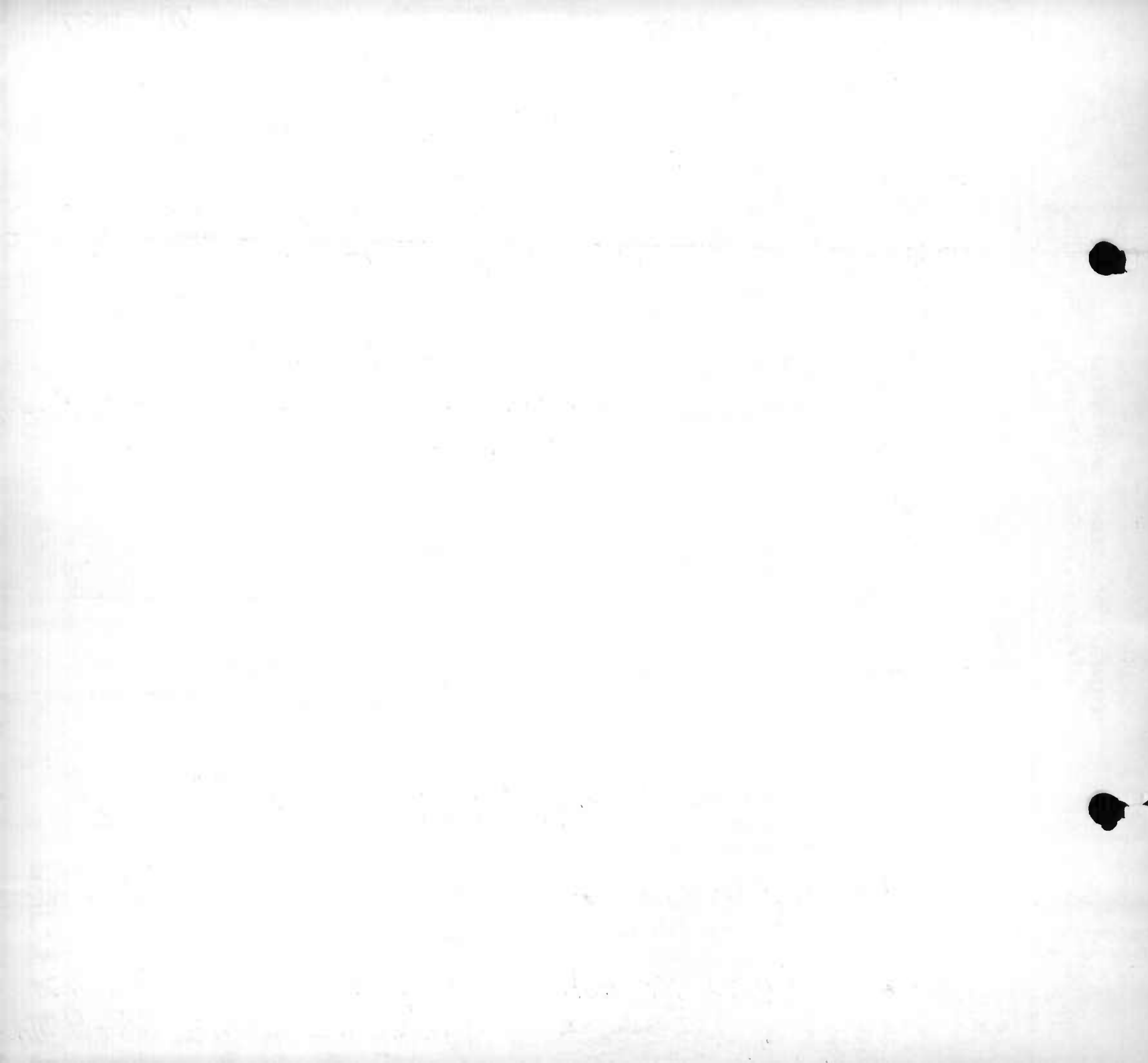
| L-150 70 1836 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1836 | |
|--|-------------------------|---|--|---|--|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print)
Marvin D. Laffoon | | 2. DATE AND HOUR OF DEATH
February 12th, 1970 9:45 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
218 N. Linwood Avenue | | | | A. STATE
Maryland | | B. COUNTY
601 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
218 N. Linwood Avenue | | | | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 18th, 1908 | | 9. AGE (In years lost birthday)
61 | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY
General Contractor | | 11. BIRTHPLACE (State or foreign country)
Duggar, Indiana | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Willard M. Laffoon | | | | 14. MOTHER'S MAIDEN NAME
Ida Samples | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
344-03-2695 | | 17. INFORMANT
Blaney Laffoon | | | |
| | | | | ADDRESS
218 N. Linwood Ave | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
157-91 | | | | CAUSE OF DEATH
Ischemic Heart Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2-3 mos | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
GI Bleeding 20 to 40 | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-24-69 to 2-13-70 , that (I) (we) last saw the deceased alive on 2-11-70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. PHYSICIAN'S NAME (Type)
Theo. T. Mizenik MD | | | | 23B. DATE SIGNED
2-14-70 | | 23C. ADDRESS
429 S Chester St 21231 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | | 24C. NAME OF CEMETERY or CREMATORY
Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State)
7225 Eastern Ave Balto. Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Frederick D. Miller Inc | | 25C. FUNERAL DIRECTOR ADDRESS
3019 Monument St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 70 1837 | |
|---|-------------------------|---|--|---|---|
| BIRTH NO. 70 1837 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Kuslar Osby | | 2. DATE AND HOUR OF DEATH
JANUARY 30, 1970 1:30 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Lutheran Hospital | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
46 | | F. STREET AND NUMBER
2810 Winsor Ave Balt. Md | | | |
| 5. SEX
Female | 6. RACE
Black | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 10, 1909 | 9. AGE (In years lost birthday)
62 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minister | | 10B. KIND OF BUSINESS OR INDUSTRY
Ministry | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John Holloway | | 14. MOTHER'S MAIDEN NAME
MARY Liza Parsons | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-36-5405 | | 17. INFORMANT
2220 GARRISON Blvd Balt | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
4/12/21
Arteriosclerotic C-V Disease | | CAUSE OF DEATH
Arteriosclerotic C-V Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerotic C-V Disease | | (B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/9/1970 to 1/9/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
W Garner | | 23B. DATE SIGNED
2/3/70 | | 23C. PHYSICIAN'S NAME (Type)
W Garner | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2/4/70 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
John E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
John E. Fisher 1900 Eutan Pl. Balt., Md. | |



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W-252

70 1838

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1838

| | | | | | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) JOHN W. WASHINGTON | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> January 30, 1970 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
1139 Vincent Street | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
January 30, 1970 5:15 P. M. | | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 1601 | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
MAY 16, 1950 | | 10. AGE (In years last birthday)
19 | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Alfred W. Washington Sr. | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Labore | | 15. MOTHER'S MAIDEN NAME
Dorothy Carter | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO.
216-52-1007 | | 18. INFORMANT
Joyce Smith, 1003 W. Lafayette Baltimore, Md | |
| 19. 304.9 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Early pneumonitis
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) Intravenous narcotism
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) _____ | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED January 31, 1970 | |
| ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/4/70 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Bo Johnson, 1900 Eutaw Pl Balt. Md | | | |

Letter from M.E.'s office

5-7-70 M.H.

ACADEMY BOND

PAT. CONTENT

VALLEY LAKE CO

U.S.A.

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L-000 70 1839

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 1839

BIRTH NO. *3471* REG. NO. _____

1. NAME OF DECEASED (Type or Print) **FRANK LEE** *111*

2. DATE OF DEATH Known ☒ Month Day Year Hour **February 15, 1970** M.

3. DATE PRONOUNCED DEAD Month Day Year Hour **February 15, 1970 1:30 A.M.**

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Johns Hopkins Hospital (DOA)

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **201**

6. SEX **Male** 7. RACE **White** 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH **April 10 1966** 10. AGE (In years lost birthday) **3** 11. BIRTHPLACE (State or foreign country) **Baltimore, Md**

12. CITIZEN OF WHAT COUNTRY? **U S A** 13. FATHER'S NAME **Frank Gouldmurn Lee Jr**

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 14B. KIND OF BUSINESS OR INDUSTRY **Child** 15. MOTHER'S MAIDEN NAME **Connie Gullett**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 17. SOCIAL SECURITY NO. **None** 18. INFORMANT ADDRESS **Connie Lee 2032 E Pratt Street**

19. **3471** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE **Hydrocephalus**
DUE TO, OR AS A CONSEQUENCE OF:

(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
II

20A. DATE OF OPERATION **0** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 21. AUTOPSY? (Yes or No) **No**

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? _____

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) _____ 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR? _____

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Charles S. Springate* M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **February 15, 1970**

EXAMINER'S NAME (Type) **Charles S. Springate, M.D.**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **Feb 17 1970** 24C. NAME OF CEMETERY or CREMATORY **Mt Carmel Carmel Cemetery** 24D. LOCATION (City, town, or county) (State) **O'Donnell Street Balto Md**

25A. DATE REC'D BY HEALTH DEPT. **FEB 16 1970** 25B. NAME OF REGISTRAR **Charles E. Taylor, R.D.** 25C. FUNERAL DIRECTOR ADDRESS **The Duffell Bros Inc 1800 E Lombard St**

III

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1840 | |
|--|--|--|---|---|---|
| BIRTH NO. H-400
1. NAME OF DECEASED
(Type or Print) EMMA HILL | | 2. DATE AND HOUR OF DEATH
2-14-70 15:00 A. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Lutheran Hospital of Md. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE md B. COUNTY 1501
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 724 Baker ST. | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-7-08 | 9. AGE (In years last birthday)
62 yrs | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
West River Md | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
William Wick's | | 14. MOTHER'S MAIDEN NAME
Mary E. Turner | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Amos Hill ADDRESS 2865 W. Lanvale St | |
| 18. CAUSE OF DEATH
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE Acidosis
 DUE TO, OR AS A CONSEQUENCE OF:

 (B) Renal failure
 DUE TO, OR AS A CONSEQUENCE OF:

 (C) </div> </div> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-7-1970 to 2-14-1970 , that (I) (we) last saw the deceased alive on 2-14-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Violeta R. Gamarra RMD DEGREE | | | | 23B. DATE SIGNED
2-14-70 | |
| 23C. PHYSICIAN'S NAME (Type)
VIOLETA R. GAMARRA R. MD | | | | 23D. ADDRESS
730 Ashburton St Baltimore Md | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 2/17/70 | | Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State) | | Balto. Md. | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Williams Funeral Home ADDRESS 319 N. Schroeder St | |
| FEB 16 1970 | | Blair E. Taylor | | | |

FUNERAL DIRECTOR: IMPORTANT

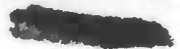
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 70 1841 | |
| BIRTH NO. 5-300 70 1841 | | M.E. CASE NO. [REDACTED] | |
| 1. NAME OF DECEASED
(Type or Print) SCHAD, MARY M. | | 2. DATE AND HOUR OF DEATH
2:27 AM on 2-13-1970 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
48 Maryland General Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 1202
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
367 HOMELAND APT. 2B | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | 8. DATE OF BIRTH
3/15/23 |
| 9. AGE (In years last birthday)
46 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BUYER - APPLIANCES | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, Md. |
| 10A. KIND OF BUSINESS OR INDUSTRY
GAS & ELEC. CO. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN A. SCHAD | | 14. MOTHER'S MAIDEN NAME
HARRIETT PRICE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-12-5232 | |
| 17. INFORMANT
MRS. HARRIETT V. SCHAD | | ADDRESS (SAME)
(SAME) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)
Aspiration of vomitus | | CAUSE OF DEATH
Aspiration of vomitus | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Chronic Ca of many 8 mos | | INTERVAL BETWEEN ONSET AND DEATH
Chronic Ca of many 8 mos | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
<input checked="" type="checkbox"/> Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
M. W. Lee | | 23B. DATE SIGNED
2-13-1970 | |
| 23C. PHYSICIAN'S NAME (Type)
M. W. LEE | | 23D. ADDRESS
Mayland General Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | |
| 24C. NAME of CEMETERY or CREMATORY
Dulaney Valley Mem. Grds. | | 24D. LOCATION (City, town, or county) (State)
Timonium, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
John E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
Henry J. Jenkins | | ADDRESS
Balto. 21228 Md. | |

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70 1842

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1842

BIRTH NO.

| | | | | | |
|---|-------------------------|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
WILLIAM H. ORRICK | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year
February 14, 1970 | | Hour
M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
South Baltimore General Hospital (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year
February 14, 1970 | | Hour
3:00 A.M. | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY BALTO. | | C. CITY OR TOWN Ruxton D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 6. SEX
Male | 7. RACE
White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER
7601 Club Rd. | |
| 9. DATE OF BIRTH
1/11/1941 | | 10. AGE (In years last birthday) 29 | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Norwood B. Orrick | | | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | 15. MOTHER'S MAIDEN NAME
Ruth Hughes | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Norwood B. Orrick | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
E-812.1 | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Multiple injuries | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 20A. DATE OF OPERATION
2-14-70 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Highway | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Balto-Wash Expressway 176 feet north of city line | |
| 22D. TIME OF INJURY (APPROX.)
Month (Day) (Year) (Hour)
2-14-70 2:10 A | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Passenger in auto which hit trailer being pulled by tractor | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
2-14-70 | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | | 24C. NAME OF CEMETERY or CREMATORY
Druid Ridge | |
| 24D. LOCATION (City, town, or county) (State)
Pikesville, Balto. Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. Md. 21212 | | | |

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MEMBER OF THE AMERICAN CATHOLIC CHURCH

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FUNERAL DIRECTOR IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the cause of death is determined cause; (5) Deceased shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|--|--------------------------|---|-------------------------------------|---|--|
| W-425 | | 70 1843 | | 70 1843 | |
| 1. NAME OF DECEASED
(Type or Print) GERTRUDE H. WILSON | | 2. DATE AND HOUR OF DEATH
2/13/70 6:15 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
Union Memorial Hosp. | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY 1202 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Union Memorial Hosp. | | C. CITY OR TOWN
Balto. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | E. STREET AND NUMBER
3215 N. Charles St. | | | |
| 5. SEX F | 6. RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/14/95 | 9. AGE (in years last birthday)
74 | 10. Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
JULIUS K. HOE MANN | | 14. MOTHER'S MAIDEN NAME
ADELE CHATIN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
220-44-3951 | | 17. INFORMANT
WILLIAM H.C. WILSON, 419 HAWTHORNE ROAD | |
| 18. 428X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
acute myocardial insufficiency | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) D.H. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
2/1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (1) (this hospital) attended the deceased from 2/12/70 to 2/13/70 that (1) (we) last saw the deceased alive on 2/12/70 and that (n)(my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
G. E. Ribben | | 23B. DATE SIGNED
2/13/70 | | 23C. PHYSICIAN'S NAME (Type)
G. E. Ribben MD | |
| 23D. ADDRESS
Union Memorial Hosp. | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
2/16/70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Greenmount | | 24D. LOCATION (City, town, or county)
Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher, R.D. | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | 25D. ADDRESS
4905 York Rd. Balto., Md. 21212 | |

[Faint handwritten text, possibly bleed-through from the reverse side]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 70 1844 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | | 70 1844 | |
|---|---------------------|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) THOMAS J RAWLINGS | | | | 2. DATE AND HOUR OF DEATH
FEB 13, 1970 9:50 A.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

42 SINAI HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MD. B. COUNTY BALTIMORE 2653 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
42 SINAI HOSPITAL | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER
3900 SOUTH CLARE RD | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12/15/90 | | 9. AGE (In years last birthday)
79 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore City | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Thomas Rawlings | | | | 14. MOTHER'S MAIDEN NAME
Mary Cooke | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
213-10-2405 | | 17. INFORMANT ADDRESS
Mrs. Mary M. Rawlings Balto. 21213 | | | |
| 18. 410.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Acute Myocardial Infarction
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ASCVD. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Acute Myocardial Infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Anemia + Hypertension | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEB. 9 19 70 to FEB 13 19 70 that (I) (we) last saw the deceased alive on FEB 13 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Victor Borden, M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
2/13/70. | | | |
| 23C. PHYSICIAN'S NAME (Type)
VICTOR BORDEN, M.D. | | | | 23D. ADDRESS
SINAI HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
Feb. 16, 70 | | 24C. NAME of CEMETERY or CREMATORY
All Saints Cemetery | | 24D. LOCATION (City, town, or county) (State)
Reisterstown, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
J. F. Eline & Sons | | ADDRESS
Reisterstown, Md. | | | |

DATE 2-1-40
PAGE 2
1/2/40

SINAI HOSPITAL
W M

Conte M...
H2C1D

Chronic - Hypertension

FEB 2 1940
FEB 19 1940
SINAI HOSPITAL

FEB 19 1940
Victor Borden M.D.
Victor Borden M.D.

FUNERAL DIRECTOR: IMPORTANT

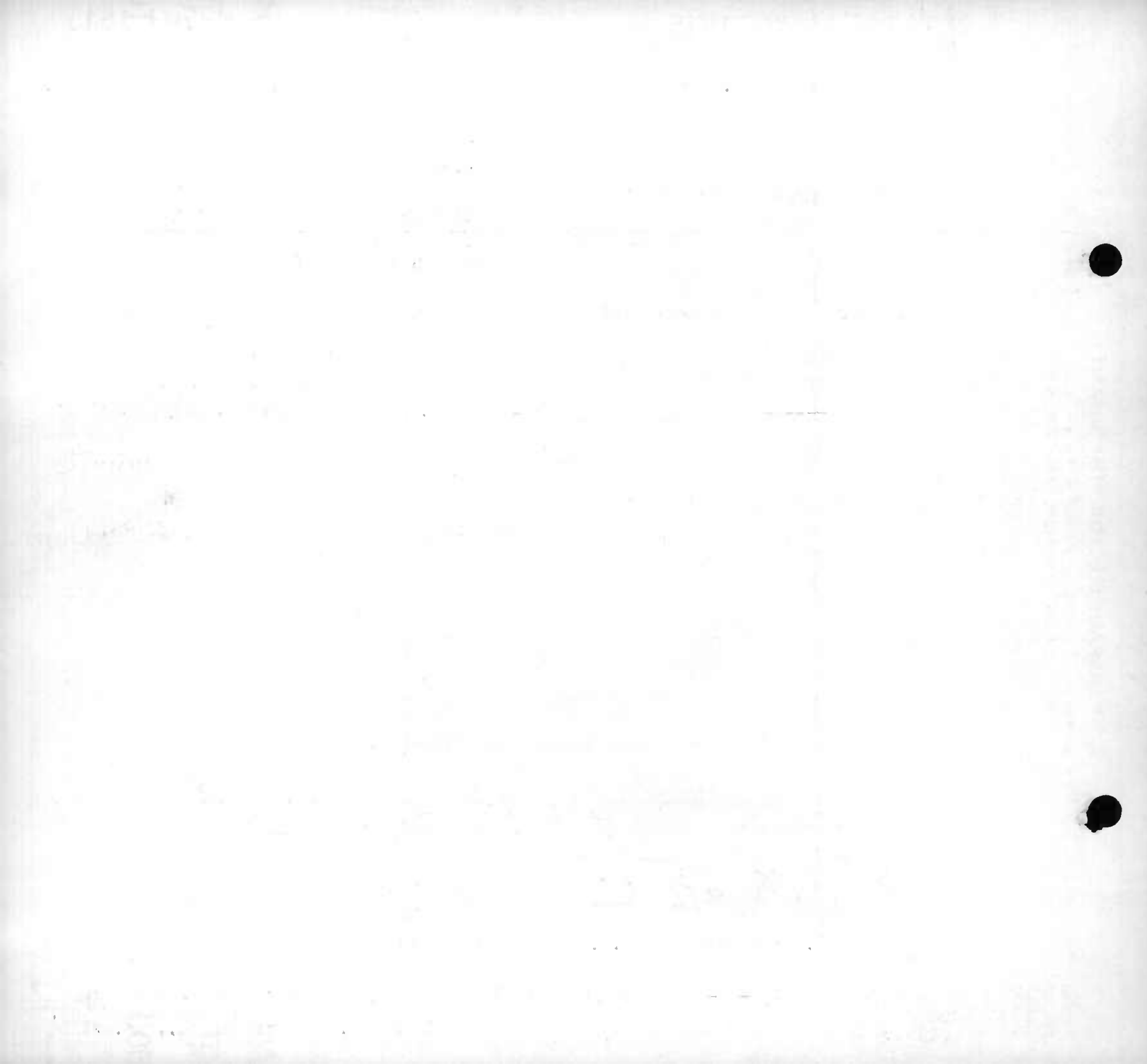
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | 70 1845 | |
|--|-------------------------|---|--|---|--|--|--|
| B-635 70 1845 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Frankford L. Braden | | | | 2. DATE AND HOUR OF DEATH
February 9, 1970 1:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 1208 Cochran Avenue 21212 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 2748
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1208 Cochran Avenue 21212 | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 15, 1887 | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Conductor | | 10B. KIND OF BUSINESS OR INDUSTRY
Rail Road | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Samuel Braden | | | | 14. MOTHER'S MAIDEN NAME
Mary Glen | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
717 07 7539-A | | 17. INFORMANT ADDRESS
Mary R. Braden 1208 Cochran Avenue Baltimore, Maryland 21212 | | | |
| 18. I 410.7
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Coronary Infarction
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerosis
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes

several yrs | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 7 1955 to Feb 9 1970 , that (I) (we) last saw the deceased alive on Feb 8 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
E. Ellsworth Cook | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
2-12-70 | |
| 23C. PHYSICIAN'S NAME (Type)
E. Ellsworth Cook M.D. | | | | 23D. ADDRESS
2431 Maryland Avenue Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-12-70 | | 24C. NAME of CEMETERY or CREMATORY
Moreland Memorial | | 24D. LOCATION (City, town, or county) (State)
Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS
William E. Johnson Balto., Md. 21204 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| <p>HBD</p> <p style="font-size: 24pt;">W-560 70 1846</p> <p style="font-size: 24pt;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 70 1846</p> | | | | | |
| <p>BIRTH NO. W-560 70 1846</p> | | <p>1. NAME OF DECEASED
(Type or Print) WOOMER, SHAIN</p> | | <p>2. DATE AND HOUR OF DEATH
FEBRUARY 11, 1970 1:10A M.</p> | |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
40 ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MARYLAND 21229</p> | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 21230 2533</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 21229 2211 SIDNEY AVENUE</p> | | | |
| <p>5. SEX MALE</p> | <p>6. RACE WHITE</p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH 12 12 08</p> | <p>9. AGE (In years last birthday) 61</p> | <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> | | <p>11. BIRTHPLACE (State or foreign country) MARYLAND</p> | |
| <p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p> | | <p>13. FATHER'S NAME MARTIN WOOMER</p> | | | |
| <p>14. MOTHER'S MAIDEN NAME HARRIET ()</p> | | <p>15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p> | | | |
| <p>16. SOCIAL SECURITY NO.</p> | | <p>17. INFORMANT BALTIMORE, MD. ST. AGNES HOSPITAL-CATON & WILKENS AVE ADDRESS 21229</p> | | | |
| <p>18. 492X I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Epistaxis & Hypertension 3 days
DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Emphysema</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> | | | | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> | | | | | |
| <p>19A. DATE OF OPERATION 0</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No) NO</p> | |
| <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | | <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | | |
| <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> | | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 9 19 70 to FEBRUARY 11 19 70 that (X) (we) last saw the deceased alive on FEBRUARY 11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE Rabunayagam MD</p> | | <p>23B. DATE SIGNED 2/11/70</p> | | <p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p> | |
| <p>23C. PHYSICIAN'S NAME (Type or Print) DR. P. SABANAYAGAN MD</p> | | <p>23D. ADDRESS CATON & WILKENS AVES. BALTO. MD. 21229</p> | | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | | <p>24B. DATE 2/15/70</p> | | <p>24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park</p> | |
| <p>24D. LOCATION (City, town, or county) (State) Dorsey, Howard Co. Md.</p> | | <p>25A. DATE REC'D BY HEALTH DEPT. FEB 16 1970</p> | | | |
| <p>25B. NAME OF REGISTRAR J. E. Bay, M.D.</p> | | <p>25C. FUNERAL DIRECTOR McCall FH ADDRESS 237 Patapsco Ave. 21225</p> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

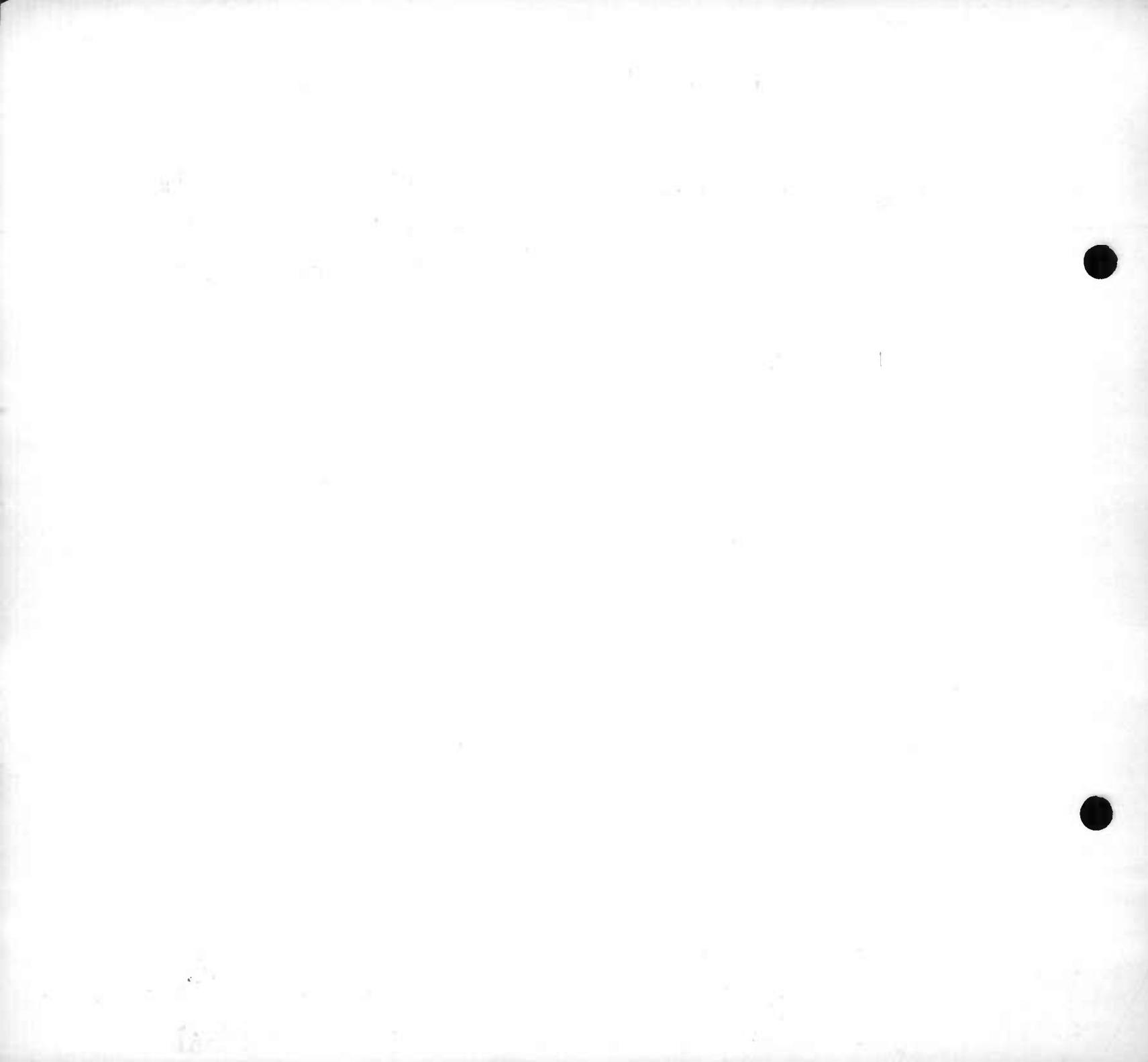
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|--|-------------------------|---|--|---|--|---|--|--|--|
| B-656 | | 70 1847 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. | | 70 1847 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) FREDERICK GOHENE BURNER | | | | 2. DATE AND HOUR OF DEATH
2/11/70 0:05 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
South Baltimore General Hospital. | | | | | | A. STATE
Maryland. | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | | B. COUNTY
BA CO. | | | |
| C. CITY OR TOWN
Baltimore | | | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER
5217 Wadena ave. | | | | | | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
6/9/92 | 9. AGE (In years last birthday)
77 | 11. Under 1 Yr. Months: Days: Hours: Min. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FORMAN | | | | 10B. KIND OF BUSINESS OR INDUSTRY
R.M. R.R. | | 11. BIRTHPLACE (State or foreign country)
Virginia. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
? | | | | 14. MOTHER'S MAIDEN NAME
Fannie ? | | | | | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
705-10-6412-A | | 17. INFORMANT
Family - Same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
44121 | | | | CAUSE OF DEATH
Cardio respiratory arrest | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hrs. | |
| i This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Prolonged shock | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
2 months. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) Abdominal Aneurysm | | | | (D) 2 months. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | Atherosclerosis Heart Disease, Similarity. | | | | | |
| 19A. DATE OF OPERATION
12/10/70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Abdominal Aneurysm. | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/9/1970 to 2/11/1970 that (I) (we) last saw the deceased alive on 2/11/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 22A. SIGNATURE
Neil Movin, M.D. | | | | 22B. DATE SIGNED
2/11/70 | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Neil Movin, M.D. | | | | 23D. ADDRESS
South Baltimore General Hosp. | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE
2/13/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Green Haven | | 24D. LOCATION (City, town, or county) (State)
Baltimore | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 16 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
McBully | | 25D. ADDRESS
3130 E. Fort Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>70 1848</u> | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. <u>70-02994</u> | | 1. NAME OF DECEASED
(Type or Print) <u>PEAKS, MONICA LYNN</u> | | 2. DATE AND HOUR OF DEATH
<u>2/14/70</u> <u>13:25 P</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>JOHNS HOPKINS HOSPITAL</u>
<u>33</u> | | | A. STATE <u>MARYLAND</u>
B. COUNTY <u>806</u> | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<u>1708 N. DURHAM STREET</u> | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>02/10/70</u> | 9. AGE (In years last birthday)
<u>4 DAYS 2 10</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>WILLOAM WHITEFIELD</u> | | | 14. MOTHER'S MAIDEN NAME
<u>BERNICE PEAKS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>53111</u>
<u>CARDIO RESPIRATORY ARREST</u> 15 min | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) <u>GASTRIC PERFORATION + PERITONITIS</u> 24 hr
(C) <u>PREMATURITY</u> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION
<u>2/13</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>GASTRIC PERFORATION</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u> | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/13</u> 19 <u>70</u> to <u>2/14</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/14</u> 19 <u>70</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>J. R. Reynold</u> | | | | 23B. DATE SIGNED
<u>2/14/70</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>J. R. Reynold, M.D.</u> | | | | 23D. ADDRESS
<u>The Johns Hopkins Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 24B. DATE
<u>2/14/70</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Johns Hopkins Hospital</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>601 N. Broadway Balto, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 17 1970</u> | | 25B. NAME OF REGISTRAR
<u>J. R. Reynold</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>HOSPITAL DISPOSAL</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|-------------------------|---|--|--|--|
| 1-520 70 1849 | | 70-03008 | | 70 1849 | |
| 1. NAME OF DECEASED
(Type or Print) Baby Boy Thomas | | | | 2. DATE AND HOUR OF DEATH
10³⁰ A 2/13/70 M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
33 The Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
A. STATE Maryland B. COUNTY Carroll C. CITY OR TOWN Westminster D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Rt. #6 | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2 PM 2/12/70 | 9. AGE (In years last birthday)
20 | 10. UNDER 1 Yr. Months: Days: 20 30 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME
Joseph | | |
| 14. MOTHER'S MAIDEN NAME
Judith | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| 18. 776.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) IMMEDIATE CAUSE Anoxia
DUE TO, OR AS A CONSEQUENCE OF:
(B) Resp arrest (apnea)
DUE TO, OR AS A CONSEQUENCE OF:
(C) Prematurity
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 1/2 hrs | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | 21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | |
| 21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/12 19 70 to 2/13 19 70 , that (I) (we) last saw the deceased alive on 2/13 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Kenneth Roberts, M.D. | | | | 23B. DATE SIGNED
2/13/70 | |
| 23C. PHYSICIAN'S NAME (Type)
Kenneth Roberts, M.D. | | | | 23D. ADDRESS
Johns Hopkins Hosp Balto Md | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
Cremation | | 24B. DATE
2/13/70 | | 24C. NAME OF CEMETERY or CREMATORY
Johns Hopkins Hospital | |
| 24D. LOCATION
601 N. Broadway Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Barber, M.D. | | 25C. FUNERAL HOME ADDRESS
HOSPITAL DISPOSAL | | | |

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Answer

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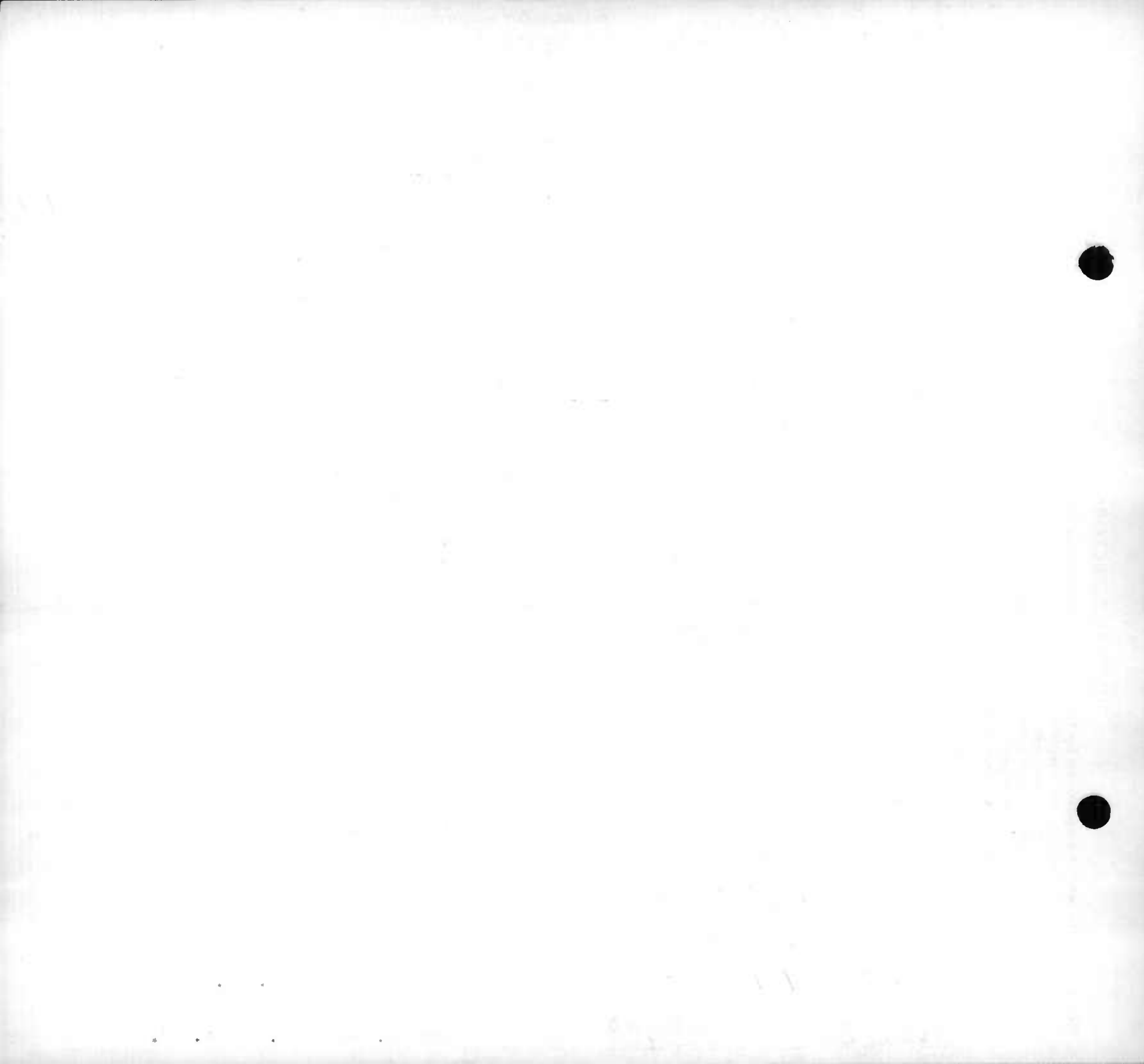
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|---|--|
| B-634 70 1850 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1850 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) PHILIP H. BARTHEL | | 2. DATE AND HOUR OF DEATH
2/14/70 1 PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
NORTH CHARLES GENERAL HOSPITAL | | A. STATE
MD. | | B. COUNTY
2652 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Baltimore, Md. | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
5605 SEWARD AVE. Baltimore, Md. | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/22/31 | 9. AGE (In years last birthday)
38 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired person | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
John Barthel | | 14. MOTHER'S MAIDEN NAME
Anna Gross | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes | | 16. SOCIAL SECURITY NO.
21-22-17959 | | 17. INFORMANT
Agnes Barthel same | |
| 18. 5-8-2X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Hypertension, Coronary artery disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Uremia - chronic renal failure | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2/17/70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/11/70 to 2/14/70 and that (I) (we) last saw the deceased alive on 2/14/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Victor Salama MD. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
VICTOR SALAMA MD. | | 23D. ADDRESS
North Charles General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/17/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | |
| 24D. LOCATION
Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | | |
| 25B. NAME OF REGISTRAR
J. J. J. J. J. | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. Md. | | | |

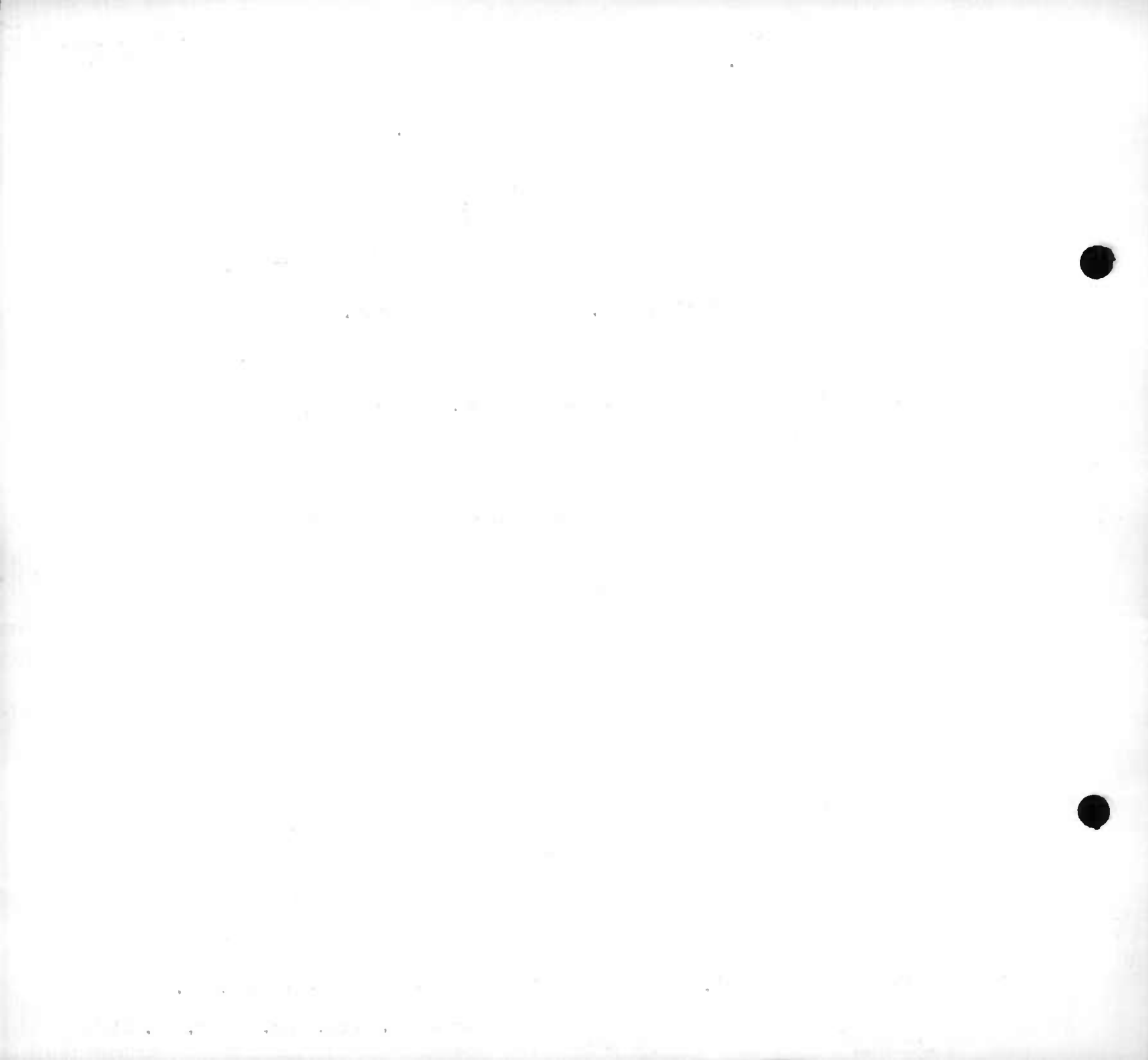


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>70 1851</u> | |
|---|--|--|---|--|------------------------------------|
| BIRTH NO. <u>H-560</u> | | 70 1851 | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>WILLIAM HENRY</u> | | | 2. DATE AND HOUR OF DEATH
<u>2-14-70</u> <u>6 PM</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

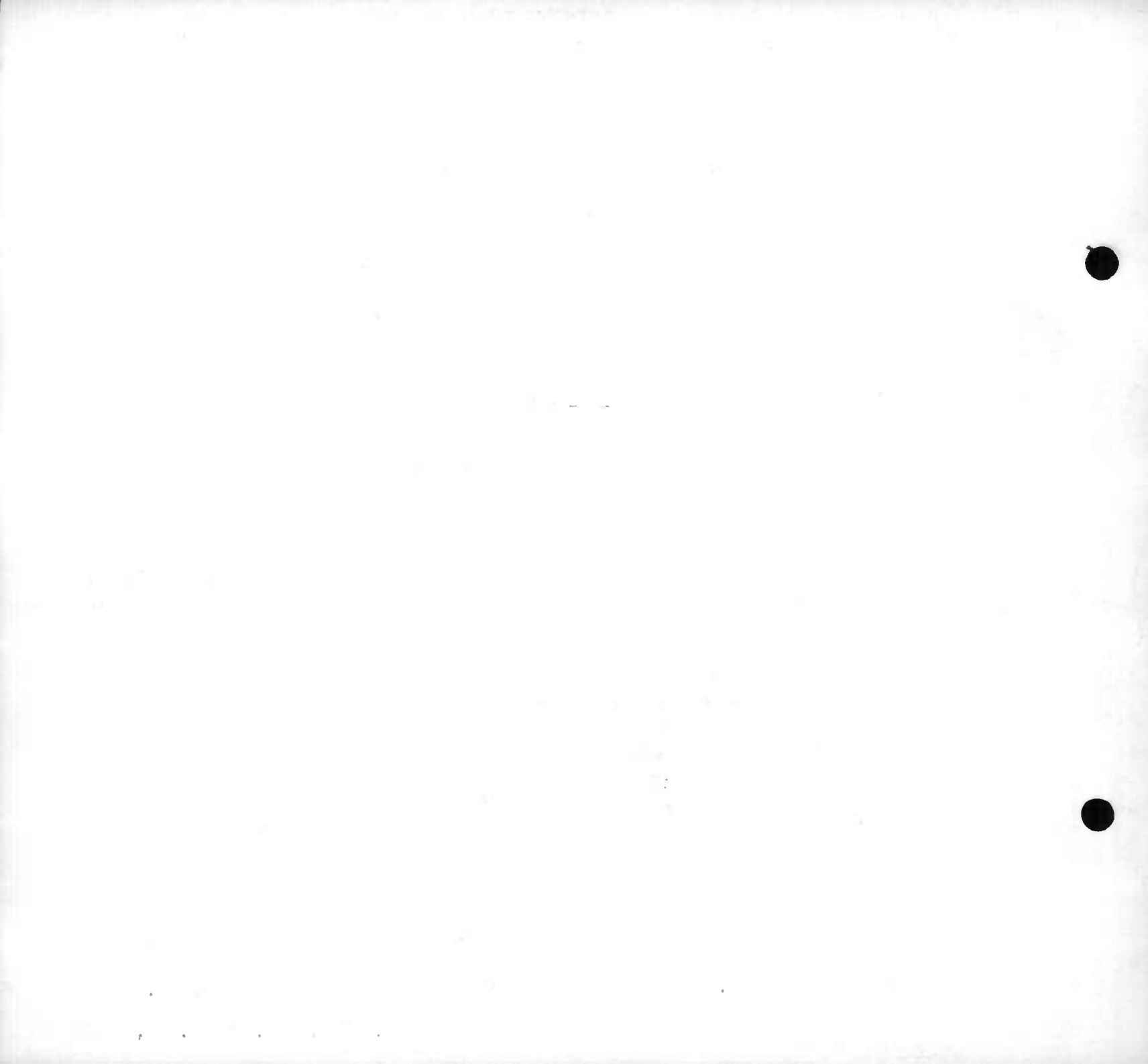
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>2 SINAI HOSPITAL of BALTIMORE</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>Md.</u> B. COUNTY <u>2748</u> | | |
| 5. SEX <u>M</u> | | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>7/26/89</u> |
| 9. AOE (in years last birthday) <u>80</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Western Electric Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Penna.</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Western Electric Co.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> <u>WW I</u> | | 16. SOCIAL SECURITY NO.
<u>216-03-5765</u> | | 17. INFORMANT
<u>Mrs. Harriett Henry</u> | |
| 18. <u>436.9 & 250.9</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>CEREBROVASCULAR ACCIDENT</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>DIABETES MELLITUS</u> | | CAUSE OF DEATH
<u>CEREBROVASCULAR ACCIDENT</u>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>ARTEROSCLEROTIC VASC. DISEASE</u>
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>60 min.</u>
<u>years.</u>
<u>years.</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-12-70</u> 19__ to <u>2-14-70</u> 19__
that (I) (we) last saw the deceased alive on <u>2-14-70</u> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>M. Bodenheimer M.D.</u> | | 23B. DATE SIGNED
<u>2-14-70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>M. BODENHEIMER, M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/18/70.</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Baltimore National Cemetery</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 17 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | 70 1852 | | REG. NO. 70 1852 | |
|---|-------------------------|---|---|---|---|---|---|
| BIRTH NO. <u>A-520</u> | | | | 1. NAME OF DECEASED
(Type or Print) <u>Amoss, Estelle S.</u> | | 2. DATE AND HOUR OF DEATH
<u>2/15 1970 4:00am</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Union Memorial Hospital</u>
<u>3rd Street Baltimore Md</u> | | | | A. STATE
<u>Maryland</u> | | B. COUNTY
<u>2733</u> | |
| | | | | C. CITY OR TOWN
<u>Balto</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<u>4713 Gwynn Ave</u> | | | |
| 5. SEX
<u>male</u> | 6. RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>07-08-89</u> | 9. AGE (in years last birthday)
<u>80</u> | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housework</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>Frank Shipley</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Adeline - (not known)</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | | 16. SOCIAL SECURITY NO.
<u>217-16-1942</u> | | 17. INFORMANT
<u>son, George V. Pearl</u> | | ADDRESS
<u>7208 Kukan Blvd.</u> |
| 18. <u>433.91</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>cerebral infarct</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>II</u> | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>cerebral infarct</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) <u>D.H.</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>2/15</u> 19 <u>70</u> to <u>2/15</u> 19 <u>70</u> that (I) <u>(we)</u> last saw the deceased alive on <u>2/15</u> 19 <u>70</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> M.D. | | | | 23B. DATE SIGNED
<u>2/15 70</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>D.P. VAN KAMMEN M.D.</u> | | | | 23D. ADDRESS
<u>U.M.H. 3rd Calvert Street Balto Md</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/18/70.</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Baltimore Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 17 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | ADDRESS | |

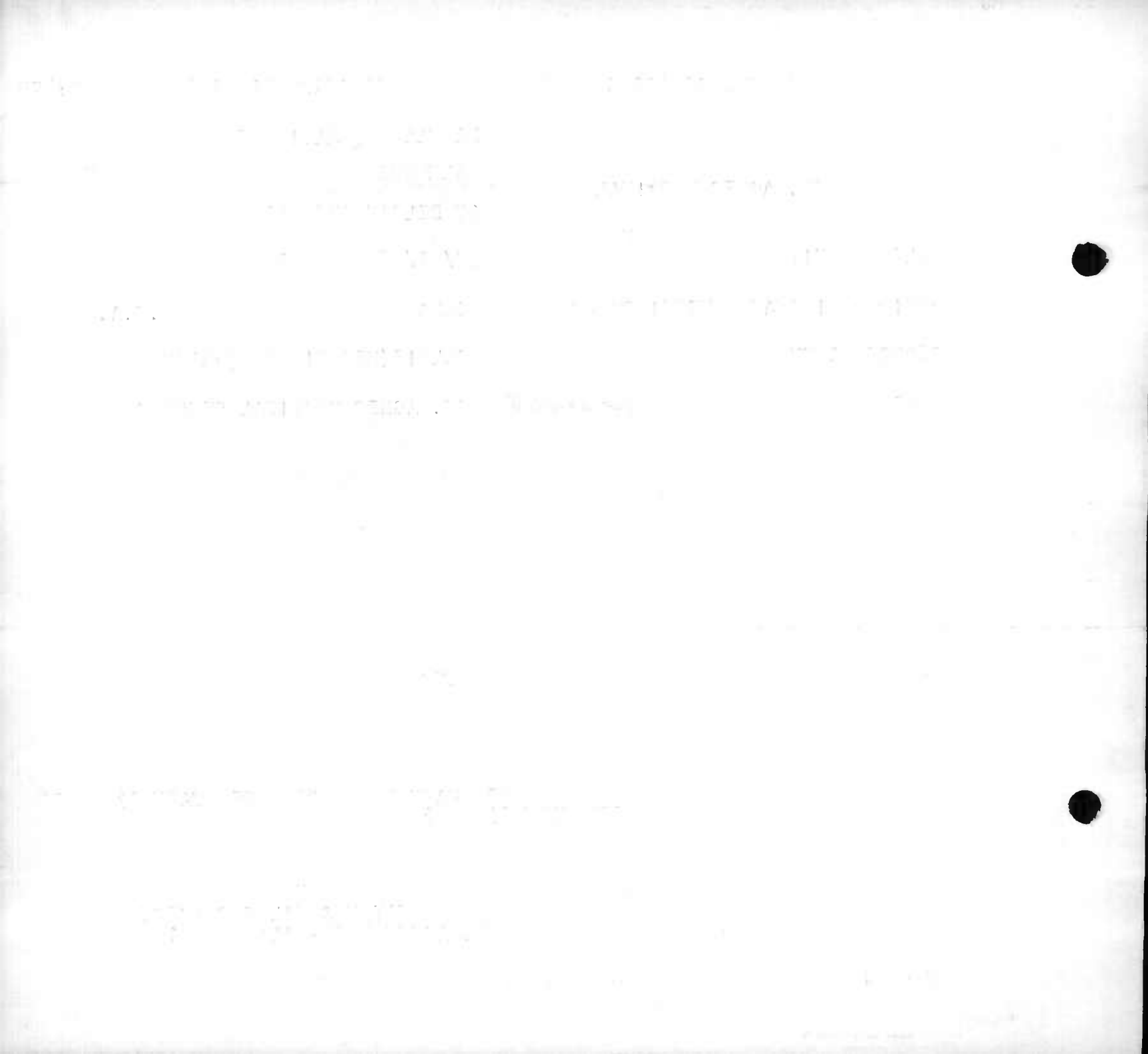


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1853</u> | |
|--|--|--|--|---|--|
| M-620 70 1853 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | MARSH, GEORGE C | | 2. DATE AND HOUR OF DEATH
FEBRUARY 13, 1970 2:45P. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

ST. AGNES HOSPITAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
MARYLAND B. COUNTY
BALTIMORE | |
| 5. SEX
MALE | | 6. RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
05/01/06 | | 9. AGE (In years last birthday)
63 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED WIREMAN | | 10B. KIND OF BUSINESS OR INDUSTRY
WEST INGHOUSE | | 11. BIRTHPLACE (State or foreign country)
PENNA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
GEORGE MARSH | | | |
| 14. MOTHER'S MAIDEN NAME
GOLDIE (NEE TIPPOTT) MARSH | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NONE | | | |
| 16. SOCIAL SECURITY NO.
208-09-8258 | | 17. INFORMANT
ST. AGNES HOSPITAL RECORDS | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>Broncho pneumonia</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2/17/70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initial medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 2 19 70 to FEBRUARY 13 19 70 that (I) (we) last saw the deceased alive on FEBRUARY 13 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Ching-Hui Tsai</u> | | 23B. DATE SIGNED
2/13/70 | | 23C. PHYSICIAN'S NAME (Type)
CHING-HUI TSAI M.D. | |
| 23D. ADDRESS
CATON & WILKENS AVES.
ST. AGNES HOSP; BALTO, MD 21229 | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | |
| 24B. DATE
2/17/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Loudon PK Cem | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
[Signature] | | 25C. FUNERAL DIRECTOR
[Signature] ADDRESS
301 Frederick | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|---|--|--|
| B-652 70 1854 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1854 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) BROWNSTEIN, MORRIS | | 2. DATE AND HOUR OF DEATH
FEB 13 - 1970 10:00 PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY 2841 | | C. CITY OR TOWN BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI-HOSPITAL OF BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
3956 DOLEFIELD AVE 21215 | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
XXXXXX 75 | 9. AGE (In years last birthday)
75 | 10. Under 1 Tr. Months; Days; If Under 24 Hrs. Hours; Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MERCHANT | | 10B. KIND OF BUSINESS OR INDUSTRY
RETAIL | | 11. BIRTHPLACE (State or foreign country)
RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
CHAIM BROWNSTEIN | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
214-22-7876 | | 17. INFORMANT BROWNSTEIN, 3956 DOLEFIELD AVE. #15
SARAH — (WIFE) ADDRESS SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
250.01T-E-882
CAUSE OF DEATH | | A. IMMEDIATE CAUSE
BILATERAL PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF:
DIABETIC ACIDOSIS; ATRIAL FIBRILLATION | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hours | |
| B. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | C. FRACTURED L HIP
(approved & released by medical examiner) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | OLD AGE; DEHYDRATED. | | | |
| 19A. DATE OF OPERATION
FEB 4 - 1970 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
FRACTURED L HIP | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
3956 DOLEFIELD AVE. | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
2 / 3 / 70 12:30 AM | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
FELL OFF THE BED | |
| 22. I certify that (I) (this hospital) attended the deceased from FEB 4 1970 to FEB 13 1970 that (I) (we) last saw the deceased alive on FEB 13 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Philip S. Yutan M.D. | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type)
PHILIP S YUTAN M.D. | |
| 23D. ADDRESS
SINAI-HOSPITAL OF BALTIMORE | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2-15-70 | |
| 24C. NAME OF CEMETERY OR CREMATORY
TIFERETH ISRAEL ANSHE SFARD | | 24D. LOCATION (City, town, or county) (State)
ROSEDALE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | |
| 25B. NAME OF REGISTRAR
E. S. S. M.D. | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | 25D. ADDRESS | |

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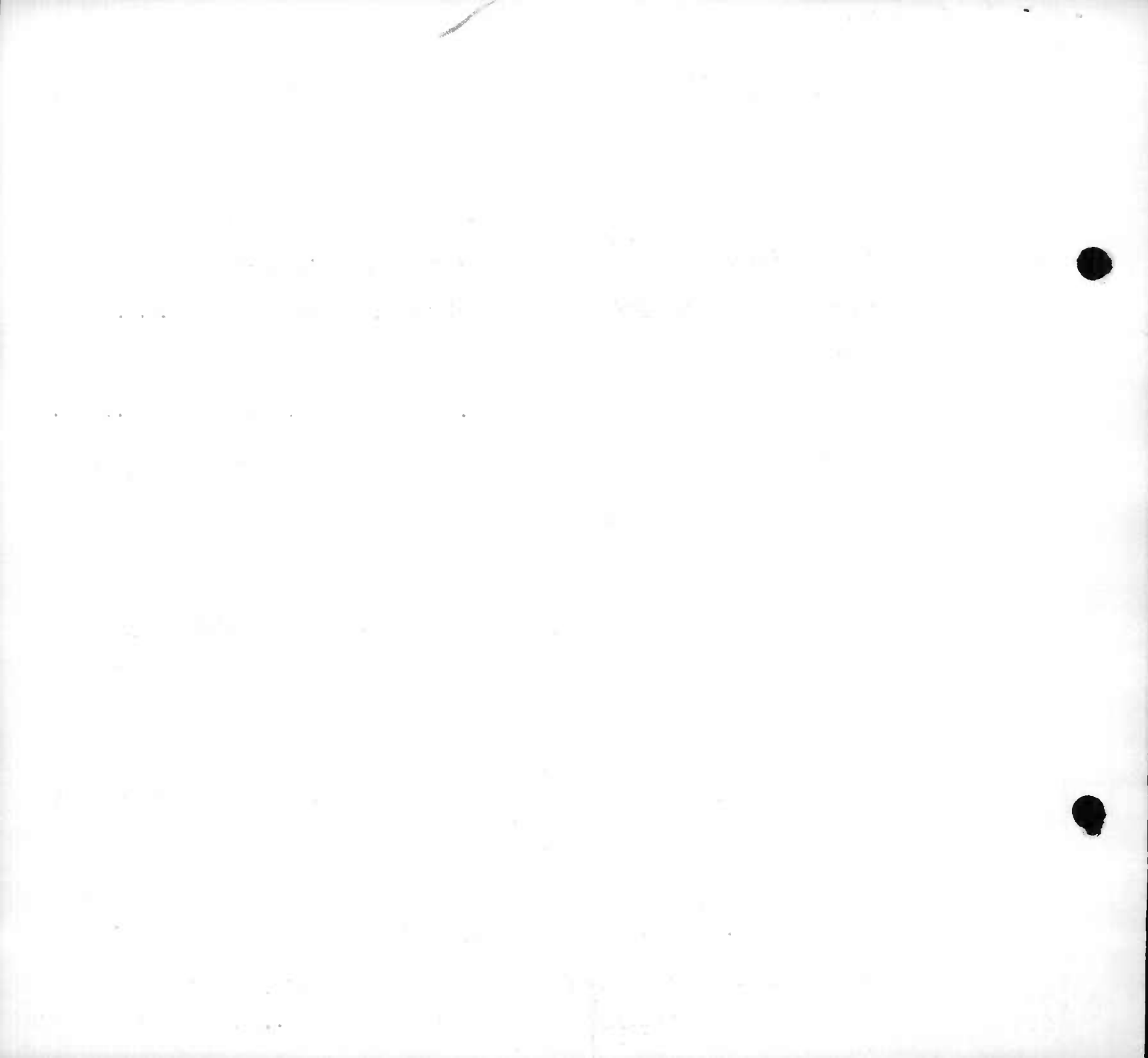
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1855</u> | |
|---|-------------------------|---|------------------------------------|---|---|
| <div style="display: flex; justify-content: space-between;"> S-240 70 1855 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>SIEGEL, MORRIS DAVID</u> | | 2. DATE AND HOUR OF DEATH
<u>2/13/70</u> <u>7:13</u> A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>SINAI HOSPITAL OF BALTIMORE</u> | | A. STATE
<u>MD. BALTIMORE CITY</u> | | B. COUNTY
<u>2740</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| <u>42</u> | | E. STREET AND NUMBER
<u>2510 KELLIM RD</u> | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1/23/16</u> | 9. AGE (In years last birthday)
<u>54</u> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>PROPRIETOR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>GROCERY</u> | | 11. BIRTHPLACE (State or foreign country)
<u>BALTIMORE, MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>HYMAN SIEGEL</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>REBECCA</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>MRS. MILDRED SIEGEL, 2510 KELLIM RD., APT. C</u> | | | |
| 18. <u>410.91</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) _____
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Rheumatic heart disease - aortic fit</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>20 years.</u> | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>2/13</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Sheldon C. Kravitz, M.D.</u> | | 23B. DATE SIGNED
<u>2-13-70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>SHELDON C. KRAVITZ</u> | |
| 23D. ADDRESS
<u>6715 Park Hts Ave.</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | | |
| 24B. DATE
<u>2-15-70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>BETH YEHUDA ANSHE KURLAND</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 17 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | X | | REG. NO. | | 70 1856 | |
|--|---------|---|------------------|--|----------------------------------|--|------------------------------|--|--|
| L-132 70 1856 | | | | BIRTH NO. | | 1 | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| BENJAMIN I. LEVITAS | | | | FEBRUARY 12, 1970 | | 11:55 | | P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

SINAI HOSPITAL
42 | | | | A. STATE | | B. COUNTY | | | |
| | | | | MARYLAND | | BALTIMORE | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | | |
| | | | | BALTIMORE | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER | | | | | |
| | | | | 6609 SHELICK PLACE #9 | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| MALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 6-29-1903 | 66 | C.P.A. | LITHUANIA | U.S.A. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| SELF EMPLOYED | | | | | | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| SAMUEL LEVITAS | | | | VETTA ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | | | | | MRS. ANNE K. LEVITAS, 6609 SHELICK PLACE #9 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | ACUTE MYOCARDIAL INFARCTION IMMEDIATE | | | |
| | | | | (B) ATTEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| | | | | (C) PRIOR MYOCARDIAL INFARCTION | | 9 YRS | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| NO | | | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from | | | | FEB 1965 | | to | | PRESENTLY 19 | |
| that (1) (we) lost saw the deceased alive on | | | | 8 Dec 19 69 | | and that in (my) (our) opinion death occurred on the date | | | |
| and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. NAME OF REGISTRAR | | 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| Malcolm S. Druskin, MD | | | | | | MALCOLM DRUSKIN | | 2217 SOUTH ROAD | |
| | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | | | 2-15-70 | | CHIZUK AMUNO (ARLINGTON) | | BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 17 1970 | | | | | | SOL LEVINSON & BROS., 6010 REISTERSTOWN RD. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1857 | |
|---|---|--|--|--|--|
| S-516 70 1857 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Isadore Scheinberg | | 2. DATE AND HOUR OF DEATH
2/12/70 11 40 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Sinai Hospital of Balto. Inc | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 2719 | | | |
| | | C. CITY OR TOWN
Balto | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER 3401 GLEN AVENUE
Belvedere Ave. at Greenspring | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/18/28 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MFG. | | 10B. KIND OF BUSINESS OR INDUSTRY
METALS | | 9. AGE (in years last birthday) 41
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 11. BIRTHPLACE (State or foreign country)
POLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
ABRAHAM SCHEINBERG | | 14. MOTHER'S MAIDEN NAME
LELA ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MR. MOSES SCHEINBERG, 1822 METZEROTT RD, ADELPHI, MD. 20783 | |
| 18. CAUSE OF DEATH
410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ASCUD = MI.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ASCUD
Acute Pulmonary Edema

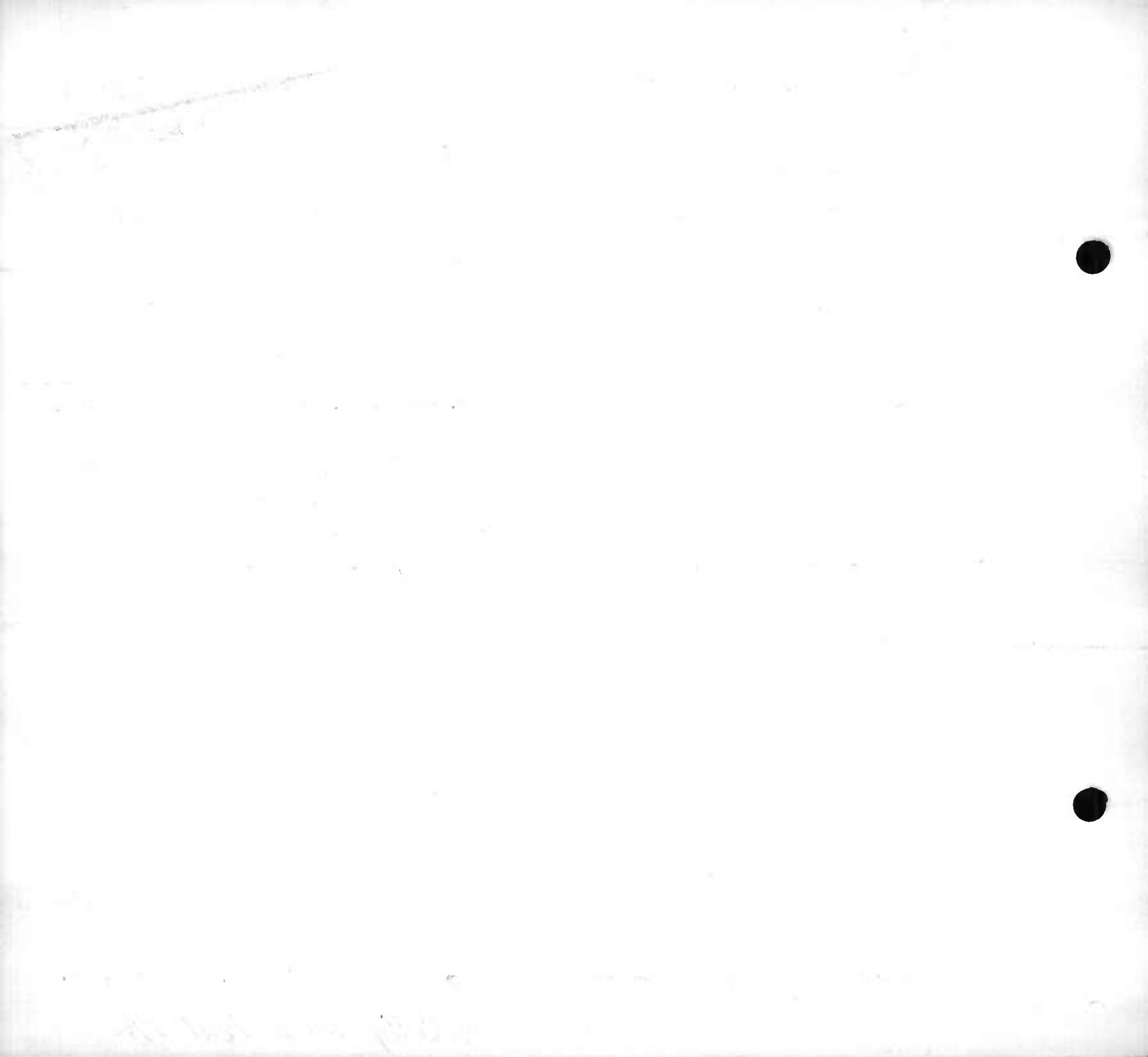
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Emphysema | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nately medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/4 1970 to 2/12 1970 that (I) (we) last saw the deceased alive on 2/12/70 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] MD | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
2/12/70 | |
| 23C. PHYSICIAN'S NAME (Type)
Carlos R. Perel MD | | 23D. ADDRESS
Belvedere Ave. at Greenspring | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2-13-70 | | 24C. NAME OF CEMETERY or CREMATORY
LUBAWITZ | |
| 24D. LOCATION
ROSEDALE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. FEB 17 1970 | | | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

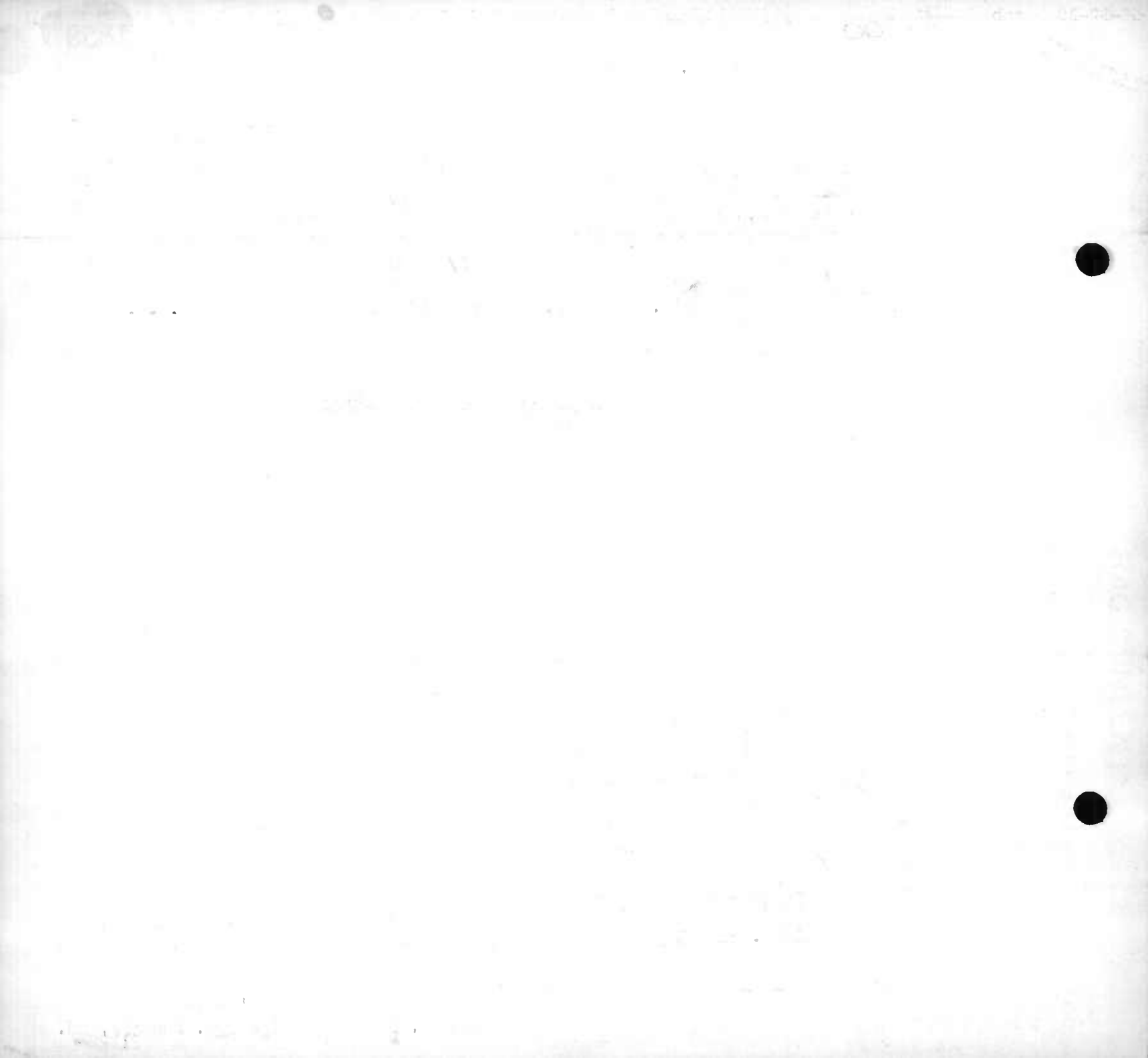
| B-650 70 1858 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | X REG. NO. 70 1858 | |
|--|-------------------------|---|--------------------------------------|---|---|--|--|--|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) Brown, Annie Oneita | | 2. DATE AND HOUR OF DEATH
Feb. 14, 1970 | | 3:30 PM M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE Maryland
B. COUNTY 5300 | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 St. Agnes Hospital
Caton & Wilkens Aves.
Baltimore, Maryland 21229 | | | | E. STREET AND NUMBER
4015 Hollins Ferry Road 21227 | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/12/1881 | 9. AGE (In years last birthday)
88 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U S A | | |
| 13. FATHER'S NAME
Ernest Hurley | | | | 14. MOTHER'S MAIDEN NAME
? Suter | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mr. Joseph B. Brown 3951 Brooklyn Ave. 21225 | | | | |
| 18. I 410.9 I CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Massive Myocardial Infarction
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Atherosclerotic Card. - Vascular Disease | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr.
5 yrs | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1967 19 to 2/14/70 19 that (I) (we) last saw the deceased alive on 2/14/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
S. McWESS M.D. | | | | 23B. DATE SIGNED
2/15/70 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
2/18/70 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Frederick Rd. Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
McBully | | 25D. ADDRESS
430 E. Fort Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

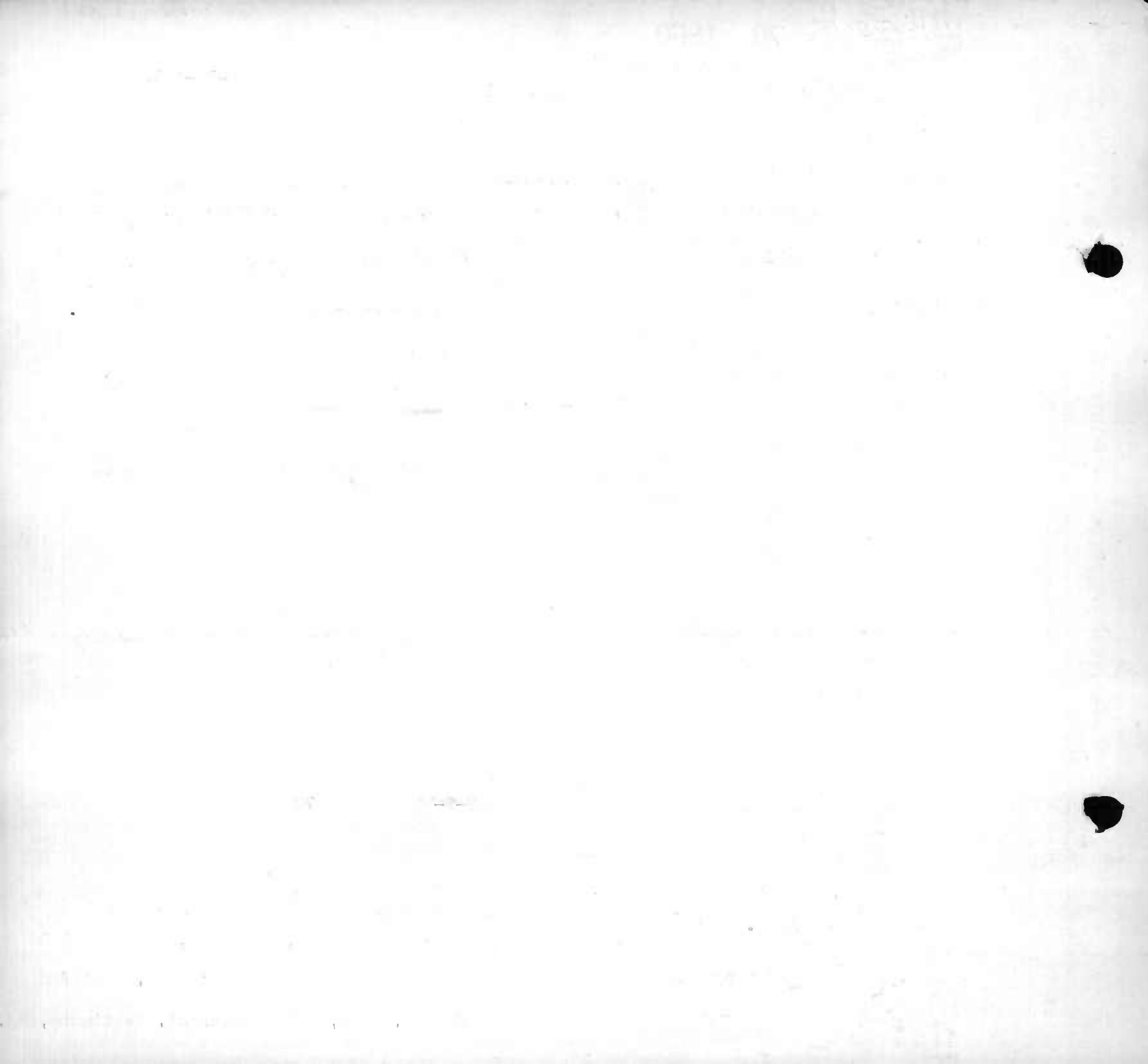
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| T-500 | | 70 1859 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | REG. NO. 70 1859 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Albert L. Thumma
ALBERT L. THUMMA | | | | 2. DATE AND HOUR OF DEATH
2/14/70 3:25 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | | | C. CITY OR TOWN
Edgemere | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 8. DATE OF BIRTH
1/3/1910 | | 9. AGE (in years last birthday) 60 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Loader | | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Beth. Steel Co. | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY
U.S.A. | | | | | | 13. FATHER'S NAME
Mitchell Thumma | | | |
| 14. MOTHER'S MAIDEN NAME
Olive Rodkey | | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
213-07-4411 | | | | | | 17. INFORMANT
Records: BCH-4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
410.9 I MYOCARDIAL INFARCTION
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 DAYS | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
SEPTICEMIA | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 HOURS | | | |
| 19A. DATE OF OPERATION
2/10 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (we) (this hospital) attended the deceased from 2/10 19 70 to 2/14 19 70 that (we) lost saw the deceased alive on 2/14 19 70 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Dennis W. Bleakley | | | | | | 23B. DATE SIGNED
2/14/70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Dennis W. Bleakley | | | | | | 23D. ADDRESS
4940 Eastern Avenue, Baltimore, Maryland-Baltimore City Hospitals 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-17-70 | | 24C. NAME OF CEMETERY or CREMATORY
Gardens of Faith | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
B 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. Faber, M.D. | | 25C. FUNERAL DIRECTOR
John J. Duda | | 25D. ADDRESS
7922 Wise Ave. Dundalk, Md. 21222 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1860 | | REG. NO. | |
|---|--|--|--|---|--|---|--|
| BIRTH NO. M-524 | | | | 70 1860 | | | |
| 1. NAME OF DECEASED
(Type or Print) HERMAN MANGLES | | | | 2. DATE AND HOUR OF DEATH
7:20 2-14-1970 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 2607 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE CITY HOSPITAL
4940 Eastern Avenue, Baltimore, Maryland | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX Male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
6-3-94 | | 9. AGE (In years last birthday) 75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
GERMANY | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME | | | |
| 14. MOTHER'S MAIDEN NAME | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
216-48-1234 J1 | | | | 17. INFORMANT
Records: BCH-4940 Eastern Avenue 21224 | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
441.21
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ASCVD | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
40 years? | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Paranoid Schizophrenia
Senile Dementia | | | | 19A. DATE OF OPERATION
0 | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-9- 19 70 to 2/14 19 70 , that (I) (we) last saw the deceased alive on 2/14 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Jaime F. Casellas | | | | 23B. DATE SIGNED
2/14/70 | | 23C. PHYSICIAN'S NAME (Type) JAMIE F. CASELLAS | |
| 23D. ADDRESS
Baltimore City Hospitals
4940 Eastern Avenue, Baltimore, Maryland 21224 | | | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24B. DATE
2/17/70 | | | | 24C. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | | | 25B. NAME OF REGISTRAR
Robert E. Faber, MD | | 25C. FUNERAL DIRECTOR
John J. Duda, 2829 Hudson St. Baltimore, Md | |



FUNERAL DIRECTOR: IMPORTANT

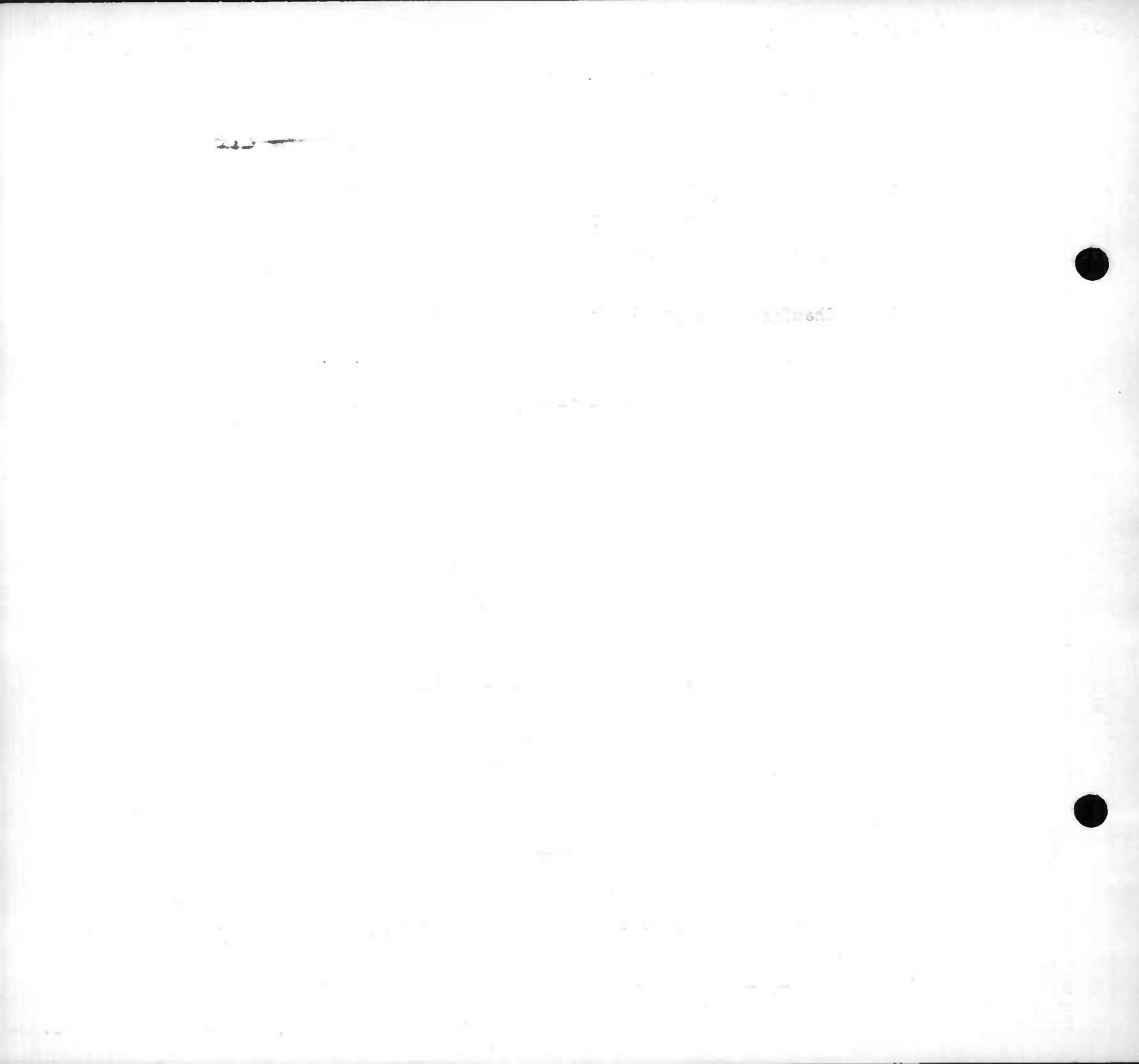
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|--|----------------------|---|-------------------------------------|---|---|
| B-650 70 1861 | | | | 70 1861 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) <u>Annie Brown</u> | |
| 2. DATE AND HOUR OF DEATH
<u>2/14/70</u> | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence below admission)
A. STATE <u>MD</u> B. COUNTY <u>1305</u> | | | | 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>U.S. PHS Hospital</u>
<u>Wyman Park Dr.</u> | |
| 6. CITY OR TOWN
<u>Baltimore</u> | | | | 7. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 8. STREET AND NUMBER
<u>3124 Chestnut St. Ave.</u> | | | | | |
| 9. SEX
<u>F</u> | 10. RACE
<u>W</u> | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 12. DATE OF BIRTH
<u>1/11/08</u> | 13. AGE (in years last birthday)
<u>61</u> | 14. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 15A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Telephone Opr.</u> | | 15B. KIND OF BUSINESS OR INDUSTRY
<u>Alex Brown & Sons</u> | | 16. BIRTHPLACE (State or foreign country)
<u>Md.</u> | |
| 17. FATHER'S NAME
<u>Henry Cusick</u> | | 18. MOTHER'S MAIDEN NAME
<u>Anna Pitcher</u> | | 19. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 21. SOCIAL SECURITY NO.
<u>176-05-0931</u> | | 22. INFORMANT ADDRESS
<u>John W. Brown - 3124 Chestnut Ave.</u> | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Myocardial Infarct, old</u> | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Coronary artery arteriosclerosis</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>2/12/70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on <u>D.O.A. Feb 14 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>R. Roger Little, M.D.</u> | | | | 23B. DATE SIGNED
<u>2/14/70</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>R. Roger Little, M. D.</u> | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/17/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Balto. National Cem.</u> | |
| 24D. LOCATION
<u>Baltimore,</u> | | 24E. (City, town, or county) (State)
<u>Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 17 1970</u> | | 25B. NAME OF REGISTRAR
<u>R. E. F. F. F.</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Ann Donovan - 3818 Roland Ave.</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 70 1862 | |
|--|--|---|--|--|--|
| BIRTH NO. 70 1862 | | 1. NAME OF DECEASED (Type or Print) <u>Kelly, Clarence W.</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>12 45pm 2/16/70</u> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| <u>Baltimore City Hospital</u>
4940 Eastern Avenue
Baltimore, Maryland 21224 | | A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> | | | |
| 5. SEX <u>M</u> | | 6. RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>3-22-03</u> | | 9. AGE (in years last birthday) <u>66</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>William Kelly</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Minnie</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>218-07-0997</u> | |
| 17. INFORMANT <u>BCH Records -</u> | | ADDRESS <u>4940 Eastern Avenue</u> | | 18. CAUSE OF DEATH | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY EMBOLUS</u> | | (B) <u>CEREBELLAR ANEURYSM</u> | |
| ANTECEDENT CAUSES | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>3/1/24/70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CEREBELLAR ANEURYSM</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/23/70</u> to <u>2/16/70</u> | | that (I) (we) last saw the deceased alive on <u>2/16/70</u> | | and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE <u>Bruce Northrup</u> | | 23B. DATE SIGNED <u>2/16/70</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Bruce Northrup M.D.</u> | |
| 23D. ADDRESS <u>Baltimore City Hospital, MD</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2-18-1970</u> | |
| 24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 17 1970</u> | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Lilly & Zeiler Inc.</u> | | ADDRESS <u>1901-07 Eastern Ave.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1863 | |
|--|--|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> 00 L-531 70 1863 </div> | | | | <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> | |
| BIRTH NO.
1. NAME OF DECEASED (Type or Print) George Lundberg | | | | 2. DATE AND HOUR OF DEATH
<div style="display: flex; justify-content: space-between;"> 2/13/70 2:30 P. M. </div> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
<div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION
 00 </div> <div> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION
 2-20-70 </div> </div> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
<div style="display: flex; justify-content: space-between;"> A. STATE
Md B. COUNTY
2854 </div> | |
| 5. SEX
Male | | | | 6. RACE
White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
June 9, 1901 | |
| 9. AGE (In years lost birthday)
68 | | | | 10. CITIZEN OF WHAT COUNTRY?
USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Minnesota | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Gustav Lundberg | | | | 14. MOTHER'S MAIDEN NAME
Ingrid | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
216-20-8817 | |
| 17. INFORMANT
Mrs. George Lundberg | | | | ADDRESS
Balto., Md. 416 Rock Glen Rd., 21229 | |
| 18. CAUSE OF DEATH
<div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

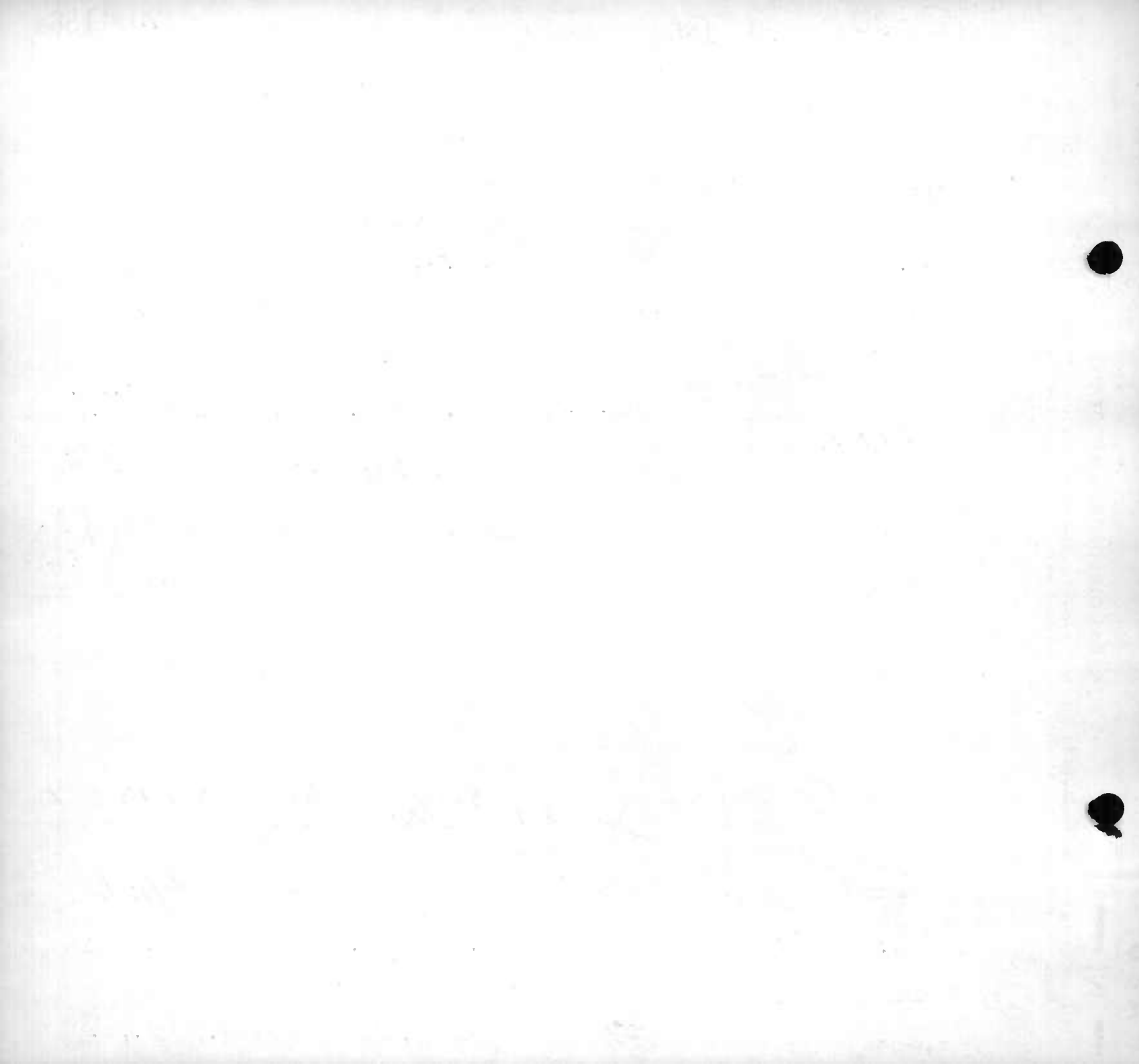
 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) IMMEDIATE CAUSE
 Chronic Lymphatic Leukemia
 DUE TO, OR AS A CONSEQUENCE OF: </div> <div> (B)
 DUE TO, OR AS A CONSEQUENCE OF: </div> <div> (C)
 DUE TO, OR AS A CONSEQUENCE OF: </div> </div> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
13 Yrs. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from Nov. 19 52 to Feb. 19 70, that (I) (we) lost saw the deceased alive on Feb. 10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Dr. Leo Gaver | | | | 23B. DATE SIGNED
2/14/70 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Leo Gaver | | | | 23D. ADDRESS
1 Mallow Hill Road | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county)
Baltimore, Maryland | | 24E. STATE
Md | | 24F. ZIP CODE
21229 | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. J. [unclear] | | 25C. FUNERAL DIRECTOR
Witzke, 4101 Edmondson Av., Balto., Md. 21229 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | REG. NO. <u>70 1864</u> | |
|---|--|--|--|--|---|--|--|---|---|--|--|
| BIRTH NO. <u>2-200 70 1864</u> | | | | | | | | | | 2. DATE AND HOUR OF DEATH
<u>February 15, 1970</u> M. | |
| 1. NAME OF DECEASED
(Type or Print)
<u>Bertha Zwick</u> | | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

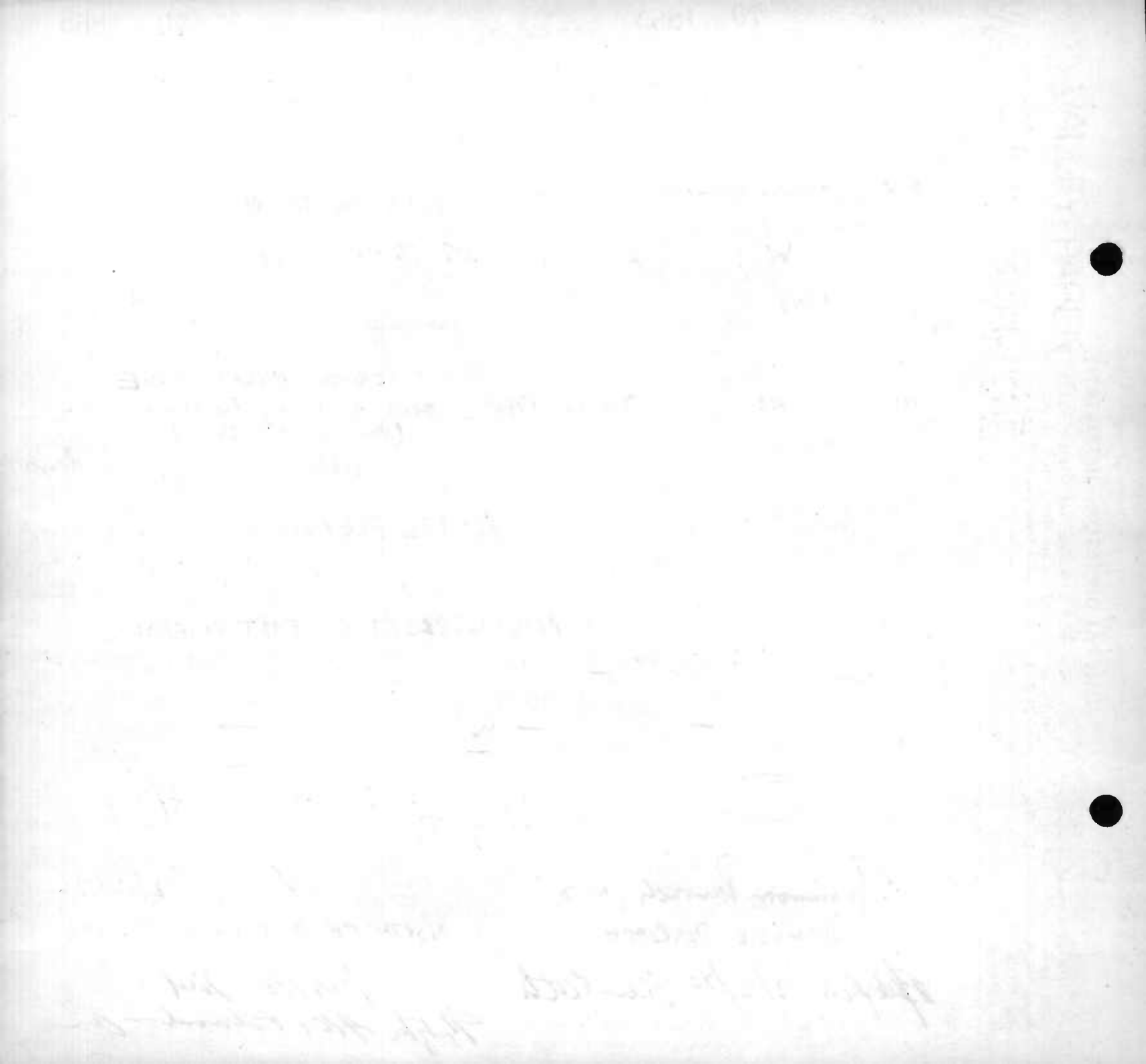
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>4631 Coleherne Road</u> | | | | | | |
| 5. SEX
<u>Fem.</u> | | | | | 6. RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Apr. 29, 1893</u> 9. AGE (In years last birthday)
<u>76</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Hendler</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Henry Zwick</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Bertha M. Metzger</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | | | | 16. SOCIAL SECURITY NO.
<u>215-03-4572</u> | | 17. INFORMANT
<u>Mrs. Henry A. Crane</u> ADDRESS
<u>Balto., Md. 425 Overbrook Rd. 21228</u> | | | | |
| 18. CAUSE OF DEATH
<u>174X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Cochran</u>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Bruce Cochran</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) <u>4 M</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 1969</u> to <u>Feb 15 1970</u> , that (I) (we) last saw the deceased alive on <u>Jan 21 1970</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<u>Raymond Bahr</u> DEGREE | | | | | | | | 23B. DATE SIGNED
<u>2/16/70</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Dr. Bahr</u> | | | 23D. ADDRESS
<u>St. Agnes Med. Center, Pine Hgts. & Wilkens Ave</u> | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 24B. DATE
<u>2/17/70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Oak Lawn Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 17 1970</u> | | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | | 25C. FUNERAL DIRECTOR
<u>Witzke</u> | | | ADDRESS
<u>4101 Edmondson Av., Balto., Md. 21229</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| C-200 | | 70 1865 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1865 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) MAMIE CASCIO | | | |
| 2. DATE AND HOUR OF DEATH
2/12/70 3:15 P.M. | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
49 NORTH CHARLES GENERAL HOSPITAL. | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 2004 | | | | 5. SEX F. 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| C. CITY OR TOWN BALTIMORE | | | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER
2103 BOOTH ST. | | | | 8. DATE OF BIRTH 09-13-90 9. AGE (In years last birthday) 79 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO NO | | | | 16. SOCIAL SECURITY NO.
215-12-3990 | | | |
| 17. INFORMANT NEIGHBOR - MARGARET VIEWEGS
2103 BOOTH ST., BALTIMORE, MD. | | | | 18. 5692 I CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
UREMIA
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
RECTAL BLEEDING | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 days
6 days | | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
ARTERIOSCLEROTIC HEART DISEASE. | | | |
| 19A. DATE OF OPERATION — | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) — | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) — | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) — | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | | 22. I certify that (I) (this hospital) attended the deceased from 2/7/1970 to 2/12/1970 , that (I) (we) last saw the deceased alive on 2/12/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Hamnoon Penroach, M.D. | |
| 23B. DATE SIGNED
2/12/70 | | 23C. PHYSICIAN'S NAME (Type)
HAMNOON PENROACH | | 23D. ADDRESS
NORTH CHARLES GEN. HOSPITAL | | 24. BURIAL CREMATION REMOVAL (Specify)
Burial | |
| 24B. DATE
2/16/70 | | 24C. NAME OF CEMETERY OR CREMATORY
New Cath. | | 24D. LOCATION (City, town, or county) (State)
BALTO MD | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Thelma H. Edwards | | 25D. ADDRESS
401 Edmondson Ave | | VS 150-REV. 1/1/68 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>70 1866</u> |
|---|--|---|--|---|
| K-280
BIRTH NO. <u>70 1866</u> | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>KOCH MR. JOSEPH A.</u> | | 2. DATE AND HOUR OF DEATH
<u>2-14-70 4 P.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD</u> B. COUNTY <u>Frederick CO</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>MARYLAND GENERAL HOSPITAL</u>
<u>48</u> | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>MALE</u> 6. RACE <u>W.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9-12-98</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NONE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>NONE</u> | | 9. AGE (In years last birthday) <u>(71) 71</u> |
| 13. FATHER'S NAME
<u>JOSEPH KOCH</u> | | 14. MOTHER'S MAIDEN NAME
<u>ADELE BEACH</u> | | 11. BIRTHPLACE (State or foreign country)
<u>GERMANY</u> |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>218-07-4717</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 17. INFORMANT
<u>Mrs. Anna Koch, Box 358, Mt. Airey, Md.</u> | | ADDRESS
<u>21771</u> | | |
| 18. CAUSE OF DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>Purulent Tracheobronchitis</u> | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>due to Irradiated Ca of larynx</u>
<u>Myelofibrosis</u> | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION
<u>2/2/70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Laryngeal obstr.</u> | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-2-</u> 19 <u>70</u> to <u>2-14</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2-14</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>Julio Gutierrez, M.D.</u> | | 23B. DATE SIGNED
<u>2-14-70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>JULIO GUTIERREZ M.D.</u> |
| 23D. ADDRESS
<u>Maryland General Hospital</u> | | 23E. FUNERAL DIRECTOR
<u>Witzke Catonsville, 1630 Edmondson Ave., Balto</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/18/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Baltimore Natl. Cemetery</u> |
| 24D. LOCATION
<u>Baltimore, Maryland</u> | | 25A. DATE RECD. BY HEALTH DEPT.
<u>FEB 17 1970</u> | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, MD</u> | | 25C. FUNERAL DIRECTOR
<u>Witzke Catonsville, 1630 Edmondson Ave., Balto</u> | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1867

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

DOROTHY ~~E. WATTS~~ WATTS2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

Maryland General Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

2

16

70

1:40 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

1803

6. SEX

7. RACE

8. MARRIED ☐NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Female

Negro

WIDOWED ☐DIVORCED ☐

Balto.

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Feb. 3, 1943

27

E. STREET AND NUMBER

121 Scott St.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter Watts

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unknown

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

Willie Lee Simmons

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Willie Lee Simmons 121 S. Scott St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Intravenous narcotism
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A.

EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

22D.

TIME
OF INJURY
(APPROX.)

(Month)

(Day)

(Year)

(Hour)

m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-16-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Feb. 20, 1970

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore

Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 17 1970

25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

Shirley O. Wilson

ADDRESS

1000 Brantley Ave.

7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1868 | |
|--|-------------------------|--|---|--|---|
| BIRTH NO. <u>67-14756</u> | | | | REG. NO. <u>70 1868</u> | |
| 1. NAME OF DECEASED
(Type or Print) <u>Everette Ball</u> | | | 2. DATE AND HOUR OF DEATH
<u>Feb. 14, 1970 1:05 A.M.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

<u>33 THE JOHNS HOPKINS HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u>
C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>114 N. MADEIRA STREET</u> | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7-29-67</u> | 9. AGE (in years last birthday)
<u>2</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Child</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore</u> | |
| 13. FATHER'S NAME
<u>JAMES BALL</u> | | | 14. MOTHER'S MAIDEN NAME
<u>BETTY ISOM</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Betty Isom Same</u> | |
| 18. <u>330.0 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)

<u>Increased intracranial pressure</u>
<u>Meningitis (Hemophilus influenzae)</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>50 hrs.</u>
<u>2-3 days</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4:30 PM, Feb 11 1970</u> to <u>10:50 AM, Feb 14 1970</u> that (I) (we) last saw the deceased alive on <u>Feb. 14 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Douglas S. Kerr</u> | | | 23B. DATE SIGNED
<u>Feb. 14, 1970</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>DOUGLAS S. KERR</u> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 24B. DATE
<u>2-17-70</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Int. Arden Cal</u> |
| 24D. LOCATION (City, town, or county)
<u>Baltimore</u> | | | 24E. FUNERAL DIRECTOR
<u>Shirley Wilson</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 17 1970</u> | | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. <u>70 1869</u> | |
| BIRTH NO. <u>W-452</u> | | 70 1869 | |
| 1. NAME OF DECEASED
(Type or Print) <u>WILLIAMS PAULINE A.</u> | | 2. DATE AND HOUR OF DEATH
<u>2-15-70</u> <u>6 00</u> A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNION MEMORIAL HOSPITAL</u>
<u>44</u> | | A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER <u>2037 HARLEM AVENUE</u> | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>01-14-14</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> <u>Nine</u> | | 9. AGE (In years last birthday) <u>56</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Kingston, Md.</u> | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>HAROLD CARTMON</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARGIE ADKINS</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT
<u>David Williams</u> ADDRESS <u>Same</u> | |
| 18. <u>430.01</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
<u>SUBARACHNOIDAL HEMORRHAGE</u>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>HYPERTENSION</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) <u>D.H.</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>02-13-70</u> 19 <u>70</u> to <u>2-15</u> 19 <u>70</u> that (I) <u>was</u> last saw the deceased alive on <u>2-14</u> 19 <u>70</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>Yes</u> (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>J. P. Mikus M.D.</u> | | 23B. DATE SIGNED
<u>2-15-70</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>J. P. MIKUS</u> | | 23D. ADDRESS
<u>UMH</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2-19-70</u> | |
| 24C. NAME OF CEMETERY or CREMATORY
<u>Carver Memorial</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Laurel Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 17 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR
<u>Edmund O. Wilson</u> | | ADDRESS
<u>1000 Brantley Ave.</u> | |



Dr. Burns

FUNERAL DIRECTOR: IMPORTANT

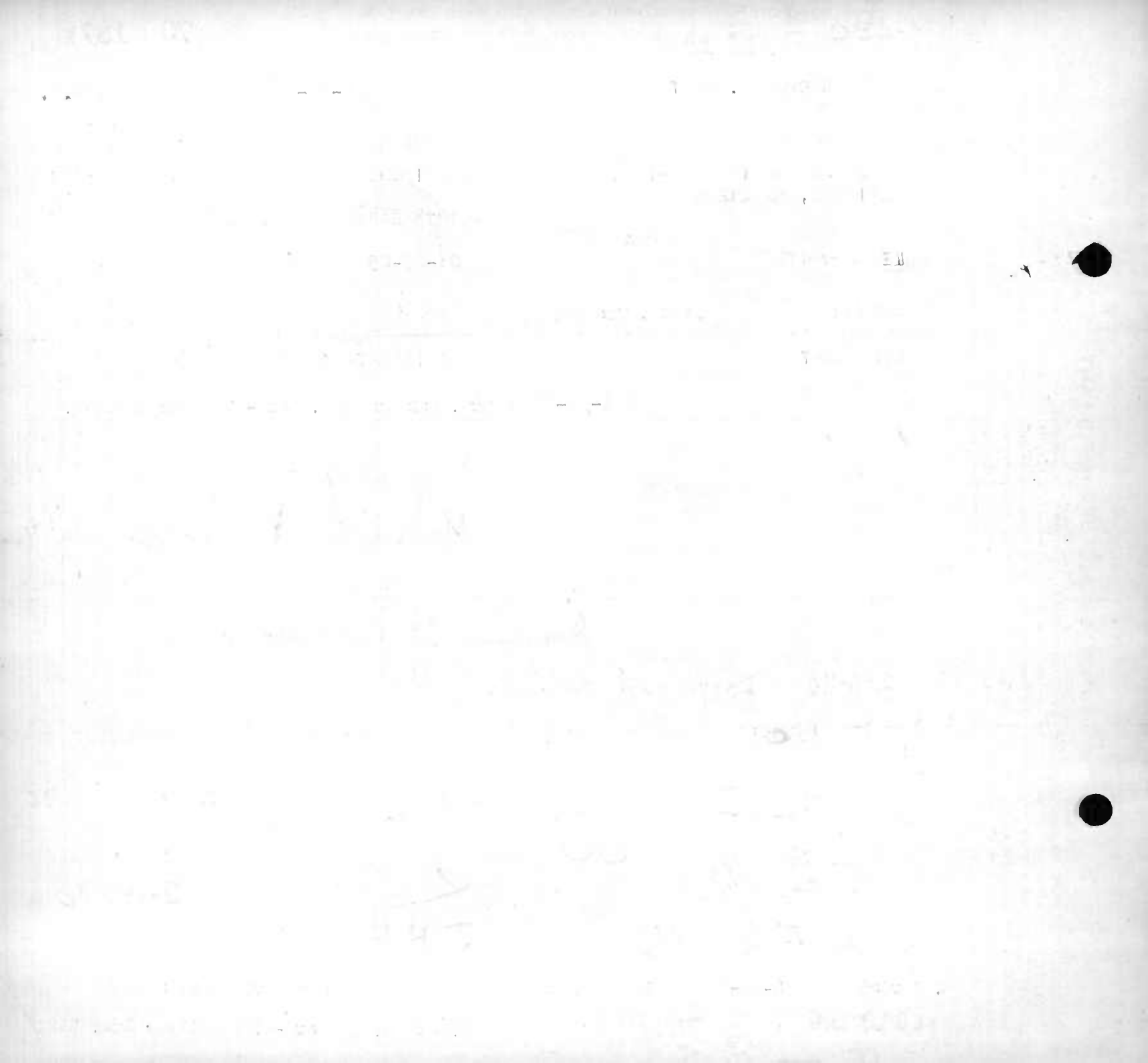
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| Z-650 | | 70 1870 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1870 | |
| BIRTH NO. | | | | 2/15/70 | | | |
| 1. NAME OF DECEASED
(Type or Print) ELIZABETH ZERAN | | | | 2. DATE AND HOUR OF DEATH | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1623 CLARKSON STREET BALTIMORE, MD. | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
FEMALE | | 6. RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 20, 1875 | |
| 9. AGE (In years last birthday)
94 | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (State or foreign country)
Hungary | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | | | 13. FATHER'S NAME
John Mittlebrun | | | |
| 14. MOTHER'S MAIDEN NAME
Katherine Zophel | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
Mrs. Rose Horvath | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
404 X I
Cardio renal vascular disease.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Cerebral Spasm.
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
19A. DATE OF OPERATION
0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
yes -
3 months | | | | | | | |
| MEDICAL CERTIFICATION
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)
21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Jan 19 70 to Feb 15 19 70, that (I) (we) last saw the deceased alive on Feb 5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Harold H Burns MD | | | | 23B. DATE SIGNED
2-16-70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS
DEGREE | | | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | |
| 24B. DATE
2 18 70 | | | | 24C. NAME OF CEMETERY or CREMATORY
Western | | | |
| 24D. LOCATION
Balto. Md. | | | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor MD | | | | 25C. FUNERAL DIRECTOR
116 Gully 130 E. Foot Ave. | | | |
| 25D. ADDRESS | | | | 25E. ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 4-630 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1871 | | | |
|---|-------------------------|---|-------------------------------------|--|----------------------------|---|-----------------------------|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) GEORGE A. HART | | | | 2. DATE AND HOUR OF DEATH
02-15-70 4 P.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS HOSPITAL | | | | A. STATE
MARYLAND | | | | B. COUNTY
2102 | | | |
| ADDRESS OR LOCATION
BALTIMORE, MD 21205 | | | | C. CITY OR TOWN
BALTIMORE | | | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER
1218 SARGEANT STREET | | | | | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH
01-23-05 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. Transit Co | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | |
| 13. FATHER'S NAME
WALTER HART | | | | 14. MOTHER'S MAIDEN NAME
ELIZABETH KNELL | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
213-05-9928 | | 17. INFORMANT
Mrs. Catherine D. Hart-1218 Sargeant St. | | ADDRESS
21223 | | | |
| 18. 162.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Respiratory Arrest
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Molastatic bronchogenic Ca 4m | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Respiratory Arrest
(B) DUE TO, OR AS A CONSEQUENCE OF:
Molastatic bronchogenic Ca 4m
(C) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Arrhythmia 2° pulmonary edema | | | | | | | | | | | |
| 19A. DATE OF OPERATION
1 2-11-70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Esophageal obstruction | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (1) this hospital attended the deceased from 2-8 19 70 to 2-15 19 70 , that (2) (we) last saw the deceased alive on 2-15 19 70 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
H. Fee MD | | | | 23B. DATE SIGNED
2-15-70 | | | | | | | |
| 23C. PHYSICIAN NAME (Type)
H. Fee MD | | | | 23D. ADDRESS
J. H. H. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-18-70 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | | | 25B. NAME OF REGISTRAR
Howard H. Hubbard | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard | | ADDRESS
4107 Wilkens Ave. 21229 | | | |



M-625 70 1872

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1872

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EARL

M.

MORGAN

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

February 14, 1970

8:25 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2582

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7-27-1886

10. AGE (In years
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2701 Washington Blvd. 1041 DeSoto Rd.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWI

17. SOCIAL
SECURITY NO.

214-10-1921

18. INFORMANT

ADDRESS 21223

Mrs. Madeline F. Ridgley-1041 DeSoto Rd.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-14-70

24A. BURIAL CREMATION,
REMOVAL (Specify)
Burial

24B. DATE

2-18-70

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FEB 17 1970

Howard H. Hubbard-4107 Wilkens Ave. 21229

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

000

VALLEY CARPERS CO

U.S.A.

RELEASED ON APPROVAL BY MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

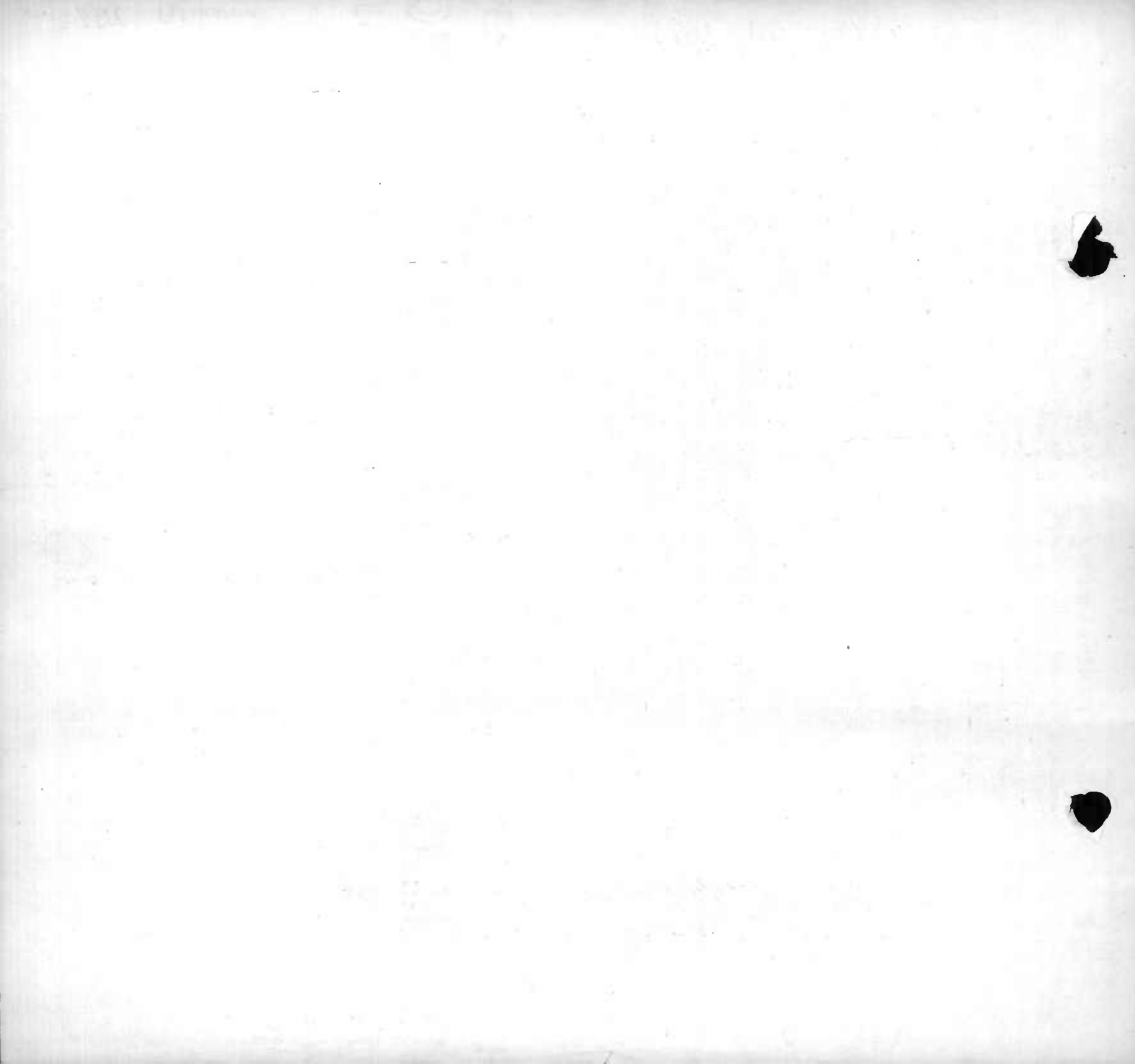
| | | | | | | | | | |
|--|---------------|---|--|--|------------------------------------|--|--|-----------------------------|--|
| D-520 | | 70, 1873 | | BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 70 1873 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) RAYMOND L. DYMICKI | | 2. DATE AND HOUR OF DEATH
2-13-1970 12 NOON | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Anne Arundel 5200
C. CITY OR TOWN Stevenson Road D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER Stevenson Road 21144 | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-28-1941 | 9. AGE (In years last birthday) 28 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor | | 10B. KIND OF BUSINESS OR INDUSTRY Westinghouse | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Walter J. Dymicki | | | | 14. MOTHER'S MAIDEN NAME Edna Wheeler | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 218-36-8697 | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
E-823119
CAUSE OF DEATH
(A) IMMEDIATE CAUSE Auto accident, generalized cerebral embolism, Bilateral broncho pneumonia, (RA)
(B) DUE TO, OR AS A CONSEQUENCE OF: spontaneous pneumothorax (bronchopneumal fistula)
(C) DUE TO, OR AS A CONSEQUENCE OF: pus, upper g-i bleeding + aspiration pneumonia
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
II
19A. DATE OF OPERATION Nov. 21-69
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED acute head injury | | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Street | | 21C. WHERE DID INJURY OCCUR? North Arundel Hosp. Drive way 5200 | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Nov. 21 69 10 PM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? auto accident | | | | | |
| 22. I certify that (this hospital) attended the deceased from Nov. 21 1969 to Feb. 13 1970 that (we) last saw the deceased alive on 2/13 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Mehdi Sarkarati M.D. DEGREE | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/13/70 | | | |
| 23C. PHYSICIAN'S NAME (Type) MEHDI SARKARATI M.D. DEGREE | | | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. B-C-R. 21224 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/17/70 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Pk. | | 24D. LOCATION (City, town, or county) Glen Burnie, Md. | | Isotel | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 17 1970 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Singleton Funeral Home? Glen Burnie, Md. R. P. W... | | ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-424 70 1874 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1874 | |
|---|-------------------------|---|------------------------------------|--|--|---|--|
| BIRTH NO. | | | | REG. NO. | | BALTIMORE CITY HEALTH DEPARTMENT | |
| 1. NAME OF DECEASED
(Type or Print) Samuel Blackwell | | | | 2. DATE AND HOUR OF DEATH
2-6-70 11:00 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
90 Bolton Hill Nursing & Convalescent Center | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 1802 | | | |
| | | | | C. CITY OR TOWN Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 1062 Vine Street | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12- -50 | | 9. AGE (In years lost birthday)
19 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
School | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Benny Blackwell | | | | 14. MOTHER'S MAIDEN NAME
Delphia Hunter | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
no | | 17. INFORMANT
Mrs Blackwell, same | | ADDRESS | |
| 18. 707.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Staph infection | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Staph infection | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12/9/69 | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
diarrhetic ulcers | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
perforated reticulatus (severe) | | 12/69
years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/26 19 70 to 2/6 19 70 , that (I) (we) last saw the deceased alive on 2/6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
[Signature] | | | | 23B. DATE SIGNED
2/7/70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
ALLAN H. MACHT MD | | | | 23D. ADDRESS
26 Pearl St Balt MD 21202 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/17/70 | | 24C. NAME OF CEMETERY or CREMATORY
Lincoln Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Rockville Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
[Signature] | | 25C. FUNERAL DIRECTOR
[Signature] | | ADDRESS
1206 W north AV | |



70 1875 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 1875

BIRTH NO. _____ REG. NO. _____

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) ERNA MAAS | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> February 14, 1970 M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Sinai Hospital (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
February 14, 1970 12:40 P.M. | |
| 6. SEX
Female | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 2719 | |
| 7. RACE
White | | C. CITY OR TOWN
Baltimore | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH
Jan 14, 1910 | | E. STREET AND NUMBER
5709 Narcissus | |
| 10. AGE (In years last birthday)
60 | | 11. BIRTHPLACE (State or foreign country)
Germany | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Leibberg | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Special Worker | | 15. MOTHER'S MAIDEN NAME
Caroline | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO.
220-30-1264 | |
| 18. INFORMANT
Miss Elsa Maas | | ADDRESS
Same | |

| | | | |
|--|--|--|--|
| 19. 428X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Focal myocardial fibrosis
DUE TO, OR AS A CONSEQUENCE OF:

(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|--|

| | | | | | |
|--|--|---|--|--|--|
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL EXAMINER'S NAME (Type) **Charles S. Springate, M.D.** CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **February 15, 1970**
ASSOCIATE MEDICAL EXAMINER ☐

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | | 24C. NAME OF CEMETERY or CREMATORY
Charles & Charles Chased | | 24D. LOCATION (City, town, or county) (State)
Randalltown mel | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. Vetter | | 25C. FUNERAL DIRECTOR
Sylvan Lewis & Son | | ADDRESS
9616 Reisterstown Rd | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1876

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD DAVID

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
February 14, 1970 11:50 P.M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

40 St. Agnes Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
February 14, 1970 11:50 P.M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

15 11

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

OCT 23, 1929

10. AGE (In years lost birthday)

80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3314 Liberty Heights Avenue

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME

David

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bookkeeper

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Hanna

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

215-28-7611

18. INFORMANT

Wife

ADDRESS

Same

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Intersection-2700 blk Wilkens Ave. &

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

1-13-70 7:45 A.

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR? Dukeland

Pedestrian struck by truck

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

February 15, 1970

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/16/70

24C. NAME OF CEMETERY or CREMATORY

Chesa-chowes Chesa

24D. LOCATION (City, town, or county)

Randallstown

Md

25A. DATE REC'D BY HEALTH DEPT.

FEB 17 1970

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Sylvan Lewis & Son 9610 Reisterstown Rd

ADDRESS

MEMORIAL BY AMERICAN SOCIETY OF DEATH

1900

John W. Smith
1870-1900

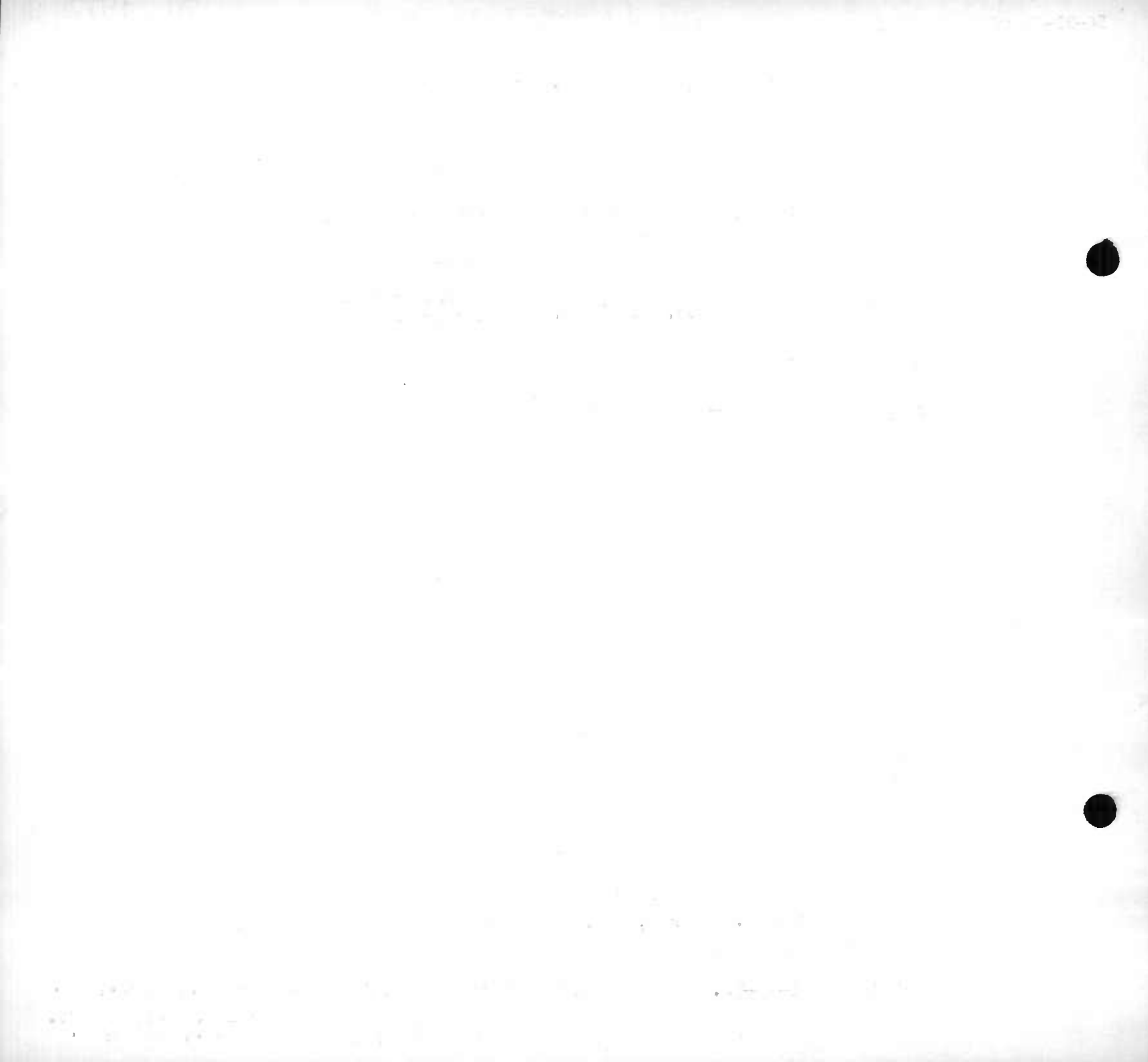
John W. Smith
1870-1900

VALLEY VIEW

John W. Smith
1870-1900

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

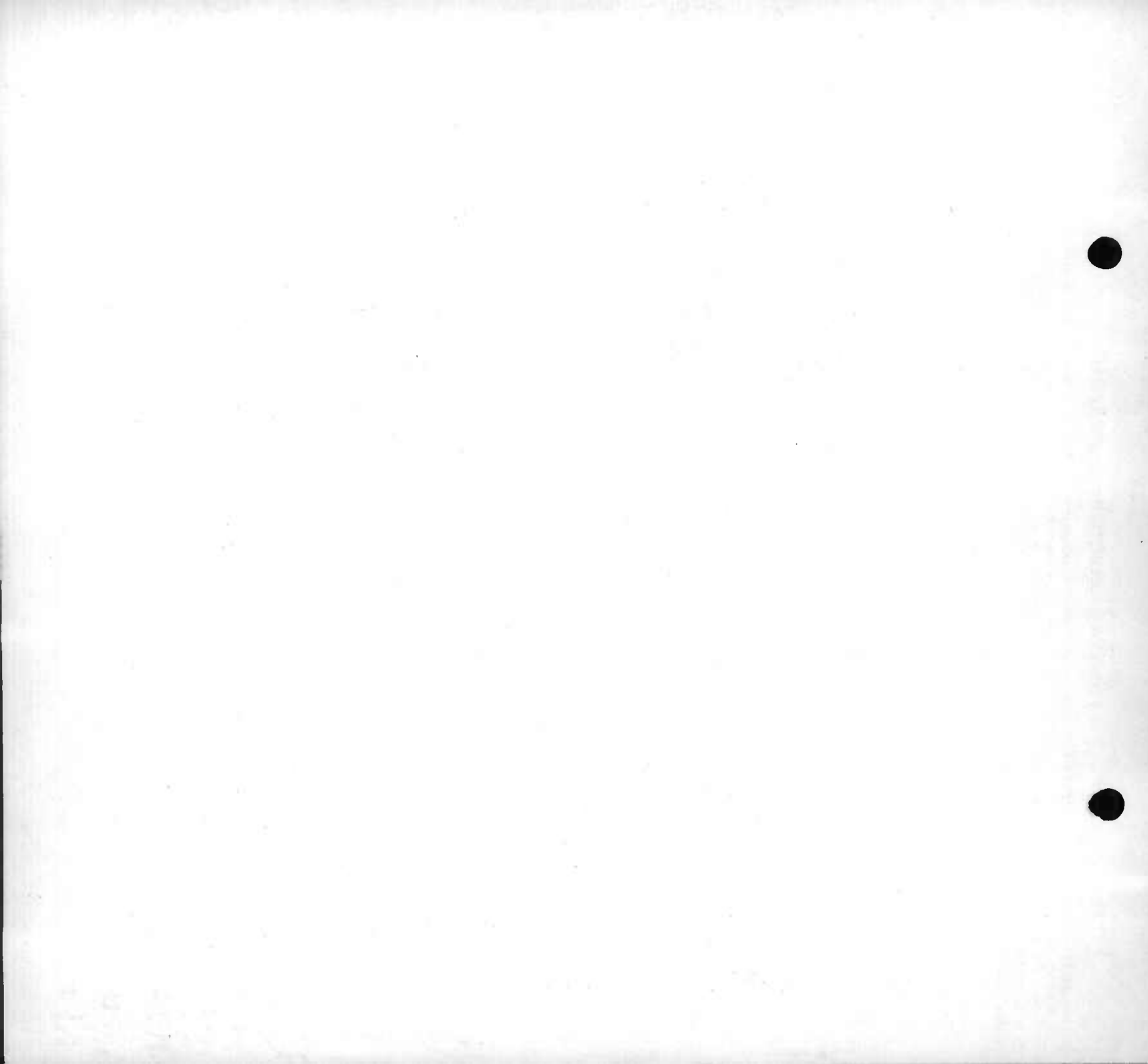
| BIRTH NO. W-346 | | | | 70 1877 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1877 | | | |
|--|--|---------------|--|---|--|--------------------------|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | REG. NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) William Woodell (WILLIAM T. WOODELL) | | | | | | | | 2. DATE AND HOUR OF DEATH
2-16-70 3:10 A.M. | | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
31 BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 632 South Macon Street 21224 | | | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-24-00 | | 9. AGE (in years last birthday) 69 | | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co. | | | | 11. BIRTHPLACE (State or foreign country) North Carolina | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Curtis Woodell | | | | | | | | 14. MOTHER'S MAIDEN NAME Minnie (Dec) | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 213-07-2109 | | | | 17. INFORMANT 4940 Eastern Avenue
BCH Records - Baltimore, Maryland 21224 | | | | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Chronic lung disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19A. DATE OF OPERATION 2-11-70 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Gastric Ulcer | | | | 20A. AUTOPSY? (Yes or No) YES | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.] | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-10-70 to 2-16-70
that (I) (we) last saw the deceased alive on 2-16-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Kenneth C. Gertsen MD | | | | | | | | 23B. DATE SIGNED 2-16-70 | | | | 23C. PHYSICIAN'S NAME (Type) Kenneth C. Gertsen, M.D.
KENNETH C. GERTSEN, MD | | | |
| 23D. ADDRESS BCH 4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 2-19-70 | | | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | | | | 24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Ba., Co., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 17 1970 | | | | 25B. NAME OF REGISTRAR Robert E. Baker | | | | 25C. FUNERAL DIRECTOR Charles J. Seiler | | | | 901 S. Conowing St.
Balto., 21224, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| C-234 | | 70 1878 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1878 | |
| BIRTH NO. | | | | 1 | | | |
| 1. NAME OF DECEASED
(Type or Print) THOMAS F. COSTELLO | | | | 2. DATE AND HOUR OF DEATH
FEB 15 1970 M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD B. COUNTY 2757 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UNION MEMORIAL HOSPITAL
BALTO. MD | | | | C. CITY OR TOWN
BALTO | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
JULY 16 1902 9. AGE (In years last birthday) 67 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 10B. KIND OF BUSINESS OR INDUSTRY RAIL ROAD | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | |
| 13. FATHER'S NAME THOMAS COSTELLO | | | | 14. MOTHER'S MAIDEN NAME NANIE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO 16. SOCIAL SECURITY NO. 212-07-5462A | | | | 17. INFORMANT SARAH COSTELLO ADDRESS 7217 OLD HARTFORD ROAD | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Coronary Occlusion
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury at complication which caused death.)
CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | | 20A. AUTOPSY? (Yes or No) — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? — | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) — | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? — | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 10 1970 to Feb 13 1970 and that (I) (we) last saw the deceased alive on Feb 13 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE James E. White MD DEGREE MD | | | | 23B. DATE SIGNED FEB. 17/70 | | | |
| 23C. PHYSICIAN'S NAME (Type) JAMES E. WHITE MD DEGREE MD | | | | 23D. ADDRESS 5214 HARTFORD RD, BALTIMORE 2124 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/18/70 | | 24C. NAME OF CEMETERY or CREMATORY MORELAND MEMORIAL | | 24D. LOCATION (City, town, or county) (State) TAYLOR AVE BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 17 1970 | | 25B. NAME OF REGISTRAR James E. White MD | | 25C. FUNERAL DIRECTOR Frederick J. Cook | | 25D. ADDRESS 7200 HARTFORD ROAD | |



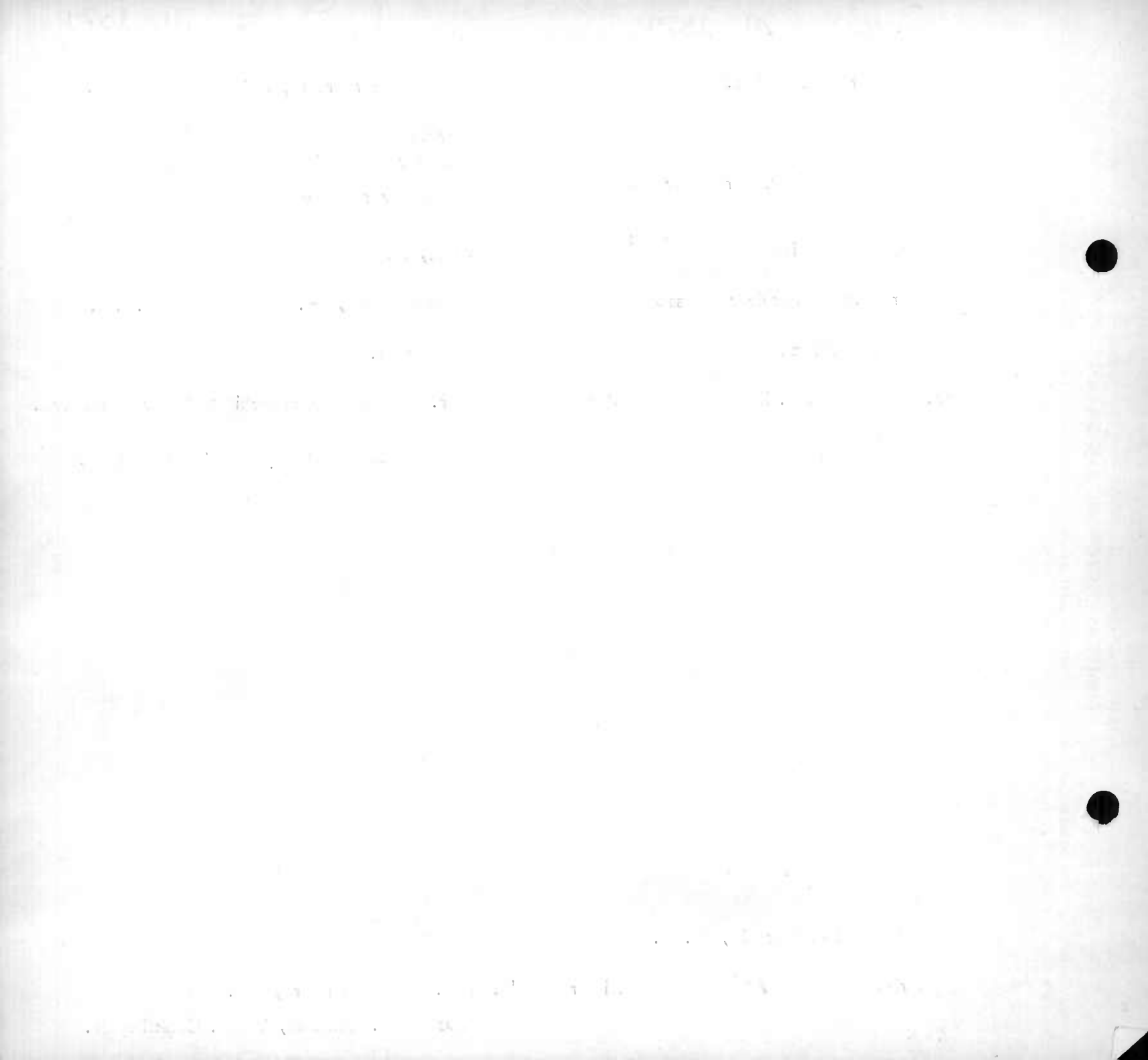
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | 70 1879 | |
|--|--|---|--|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> S-342 70 1879 </div> | | | | <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> | | | |
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print) George J. Stulock | | | | 2. DATE AND HOUR OF DEATH
February 16, 1970 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00 3409 Leverton Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 2608
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3409 Leverton Avenue | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 22, 1916 | |
| 9. AGE (In years last birthday) 53 | | 10. UNDER 1 Yr. Months: Days: | | 11. UNDER 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Warehouse Supervisor | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Esskay | | 11. BIRTHPLACE (State or foreign country)
West Newton, Pa. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
John Stulock | | | | 14. MOTHER'S MAIDEN NAME
unk. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes. | | W.W. II | | 16. SOCIAL SECURITY NO.
213-05-6503 | | 17. INFORMANT
Mr. Anthony Kowalewski | |
| | | | | ADDRESS
4308 Greenhill Ave. | | | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
MYOCARDIAL INFARCTION
ATHEROSCLEROTIC C.V.D.S. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs
2-5 hrs | |
| | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/19/70 to 2/16/70 , that (I) (we) last saw the deceased alive on 1/31/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Benjamin Highstein | | | | 23B. DATE SIGNED
2/16/70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Benjamin Highstein, M. D. | | | | 23D. ADDRESS
121 S. HIGHLAND Ave Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/70 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Nat'l. Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. [Signature] | | 25C. FUNERAL DIRECTOR
Joseph N. Zannino | | ADDRESS
263 S. Conkling St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|---------|--|---|--|--------------------------------|
| S-530 70 1880 | | | | 70 1880 | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| EARL R. SMITH | | | | 2/13/70 4:05 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| 33 Johns Hopkins Hospital | | | | MARYLAND 909 | |
| | | | | C. CITY OR TOWN D. INSIDE CITY LIMITS? | |
| | | | | BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | |
| | | | | 1809 Aiken St. | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| MALE | NEGRO | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8-27-21 | 48 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| | | | Maryland | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| PHLANDUS SMITH | | | KATHERINE QUICKLEY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes WWII | | 212-14-9003 | | Eleanora E. Smith 1809 Aiken St. | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| I
250.9
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
BASILAR ARTERY STROKE

(B) DIABETES, HYPERTENSION, ASCVD
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/12 1970 to 2/13 1970, that (I) (we) last saw the deceased alive on 2/13 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Ralph DeFrongo, M.D. OEGREE | | | | 2/13/70 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| RALPH DEFONZO, M.D. OEGREE | | | | Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/18/70 | | Balto National Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| | | | | Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 17 1970 | | John G. March | | 928 E. North Ave. | |

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 70 1881 REG. NO. 70 1881

1. NAME OF DECEASED (Type or Print) LEON G. BOWEN

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour M.
February 15, 1970

3. DATE PRONOUNCED DEAD Month Day Year Hour
February 15, 1970 4:22 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Provident Hospital (DOA)

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 1403

6. SEX Male 7. RACE Negro 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH 8-18-12 10. AGE (In years (last birthday) 57 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? Henry Bowen

13. FATHER'S NAME Henry Bowen

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 14B. KIND OF BUSINESS OR INDUSTRY Clara

15. MOTHER'S MAIDEN NAME Clara

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II 17. SOCIAL SECURITY NO. 220-07-8062 18. MARGARET BOWEN 2136 McCulloh St.

19. 444.21 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Massive intestinal necrosis

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES Thromboembolism of superior mesenteric artery

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive and arteriosclerotic cardiovascular disease

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Yes 21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? 22C. WHERE DID (If in Baltimore City, give exact location)

22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 22E. INJURY OCCURRED 22F. HOW DID INJURY OCCUR?

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED February 15, 1970

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 2/19/70 24C. NAME OF CEMETERY or CREMATORY Balto National Cem. 24D. LOCATION (City, town, or county) (State) Balto., Md.

25A. DATE REC'D BY HEALTH DEPT. FEB 17 1970 25B. NAME OF REGISTRAR Robert E. Sabin, M.D. 25C. FUNERAL DIRECTOR Wm C March ADDRESS 928 E. North Ave.

RAW LITHO
VALLEY PAPER CO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

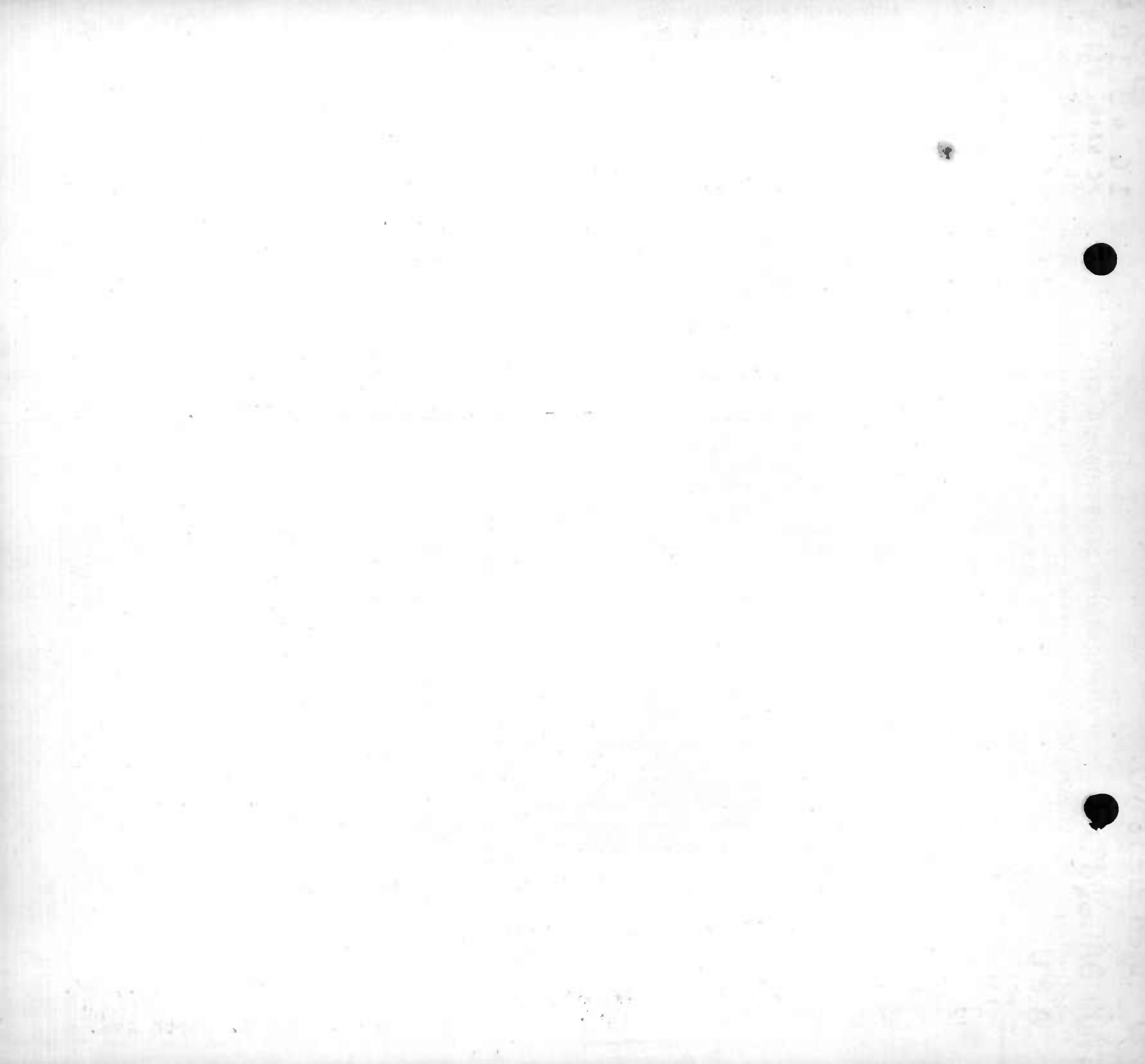
| 70 1882 BALTIMORE CITY HEALTH DEPARTMENT
V. CERTIFICATE OF DEATH | | | | REG. NO. 70 1882 | |
|--|------------------|---|--|--|---|
| 1. NAME OF DECEASED
(Type or Print) Nita Alewine | | | 2. DATE AND HOUR OF DEATH
2-13-70 11:30 PM | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
44 UNION MEMORIAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 908
C. CITY OR TOWN BALTO.
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 541 E. 23rd St. | | |
| 5. SEX F | 6. RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-29-56 | 9. AGE (in years last birthday) 13 | 10. Under 1 Yr. Months <input type="checkbox"/> Days <input type="checkbox"/> If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | |
| 13. FATHER'S NAME
JAMES ALEWINE | | | 14. MOTHER'S MAIDEN NAME
MOSETTA EVANS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
RALPH GRUPPO, MD
ADDRESS
UNION MEMORIAL HOSPITAL |
| 18. 438.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
causal edema
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
D.H. | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 13 1970 to Feb 13 1970 that (I) (we) last saw the deceased alive on Feb 13 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
R. Gruppo | | | 23B. DATE SIGNED
2-13-70 | | 23C. PHYSICIAN'S NAME (Type)
RALPH GRUPPO |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
2/18/70 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Calvary Cem |
| 24D. LOCATION (City, town, or county) (State)
Anne Arundel City | | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, MD | | | 25C. FUNERAL DIRECTOR
WMACT MARCH 928 E North Ave | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

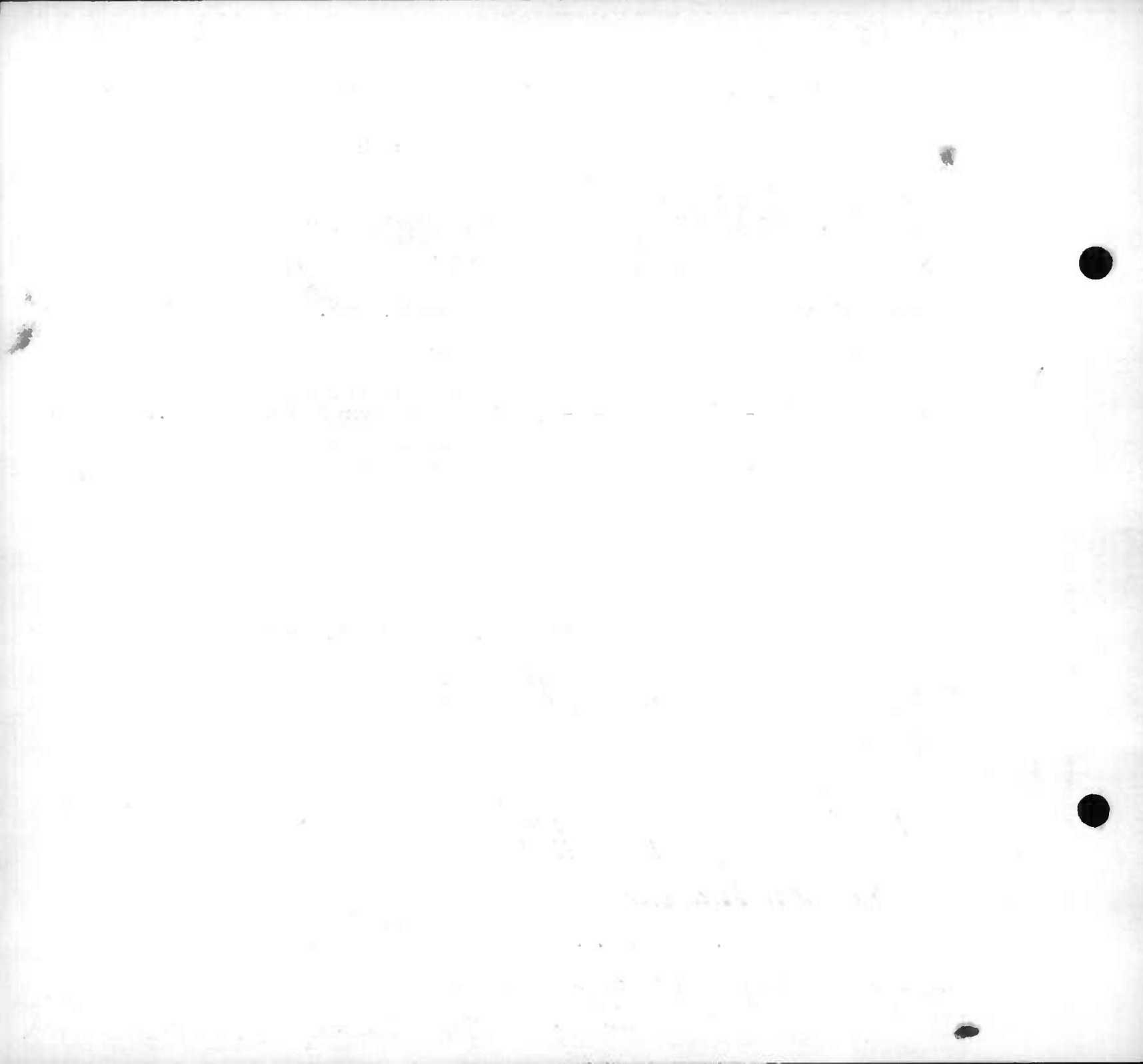
| | | | | | | | |
|---|--|---------------|--|--|--|------------------|--|
| 16 45 10
MC NAIR, PETER | | M-256 70 1883 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1883 | |
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) PETER McNAIR | | | |
| 2. DATE AND HOUR OF DEATH
2/13/70 | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE CITY | | | | 5. SEX MALE 6. RACE NEGRO | | | |
| C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| E. STREET AND NUMBER 1105 E. MONUMENT STREET | | | | 8. DATE OF BIRTH 1-3-82 9. AGE (In years lost birthday) 88 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME JORDAN McNAIR | | | | 14. MOTHER'S MAIDEN NAME MARY McCarthy | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 212-0593393 | | | |
| 17. INFORMANT Victoria Parker | | | | ADDRESS 1105 E. Monument St | | | |
| 18. 195.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH SEPSIS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 HRS | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | (B) PROBABLE INTRA ABDOMINAL MALIGNANCY | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. AUTOPSY? (Yes or No) YES | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/31 19 70 to 2/13 19 70 , that (I) (we) last saw the deceased alive on 2/13 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Robert S. Weinberg MD | | | | 23B. DATE SIGNED 2/13/70 | | | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT S. WEINBERG M.D. | | | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 2/17/70 | | | |
| 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 17 1970 | | | | 25B. NAME OF REGISTRAR Robert E. Fisher | | | |
| 25C. FUNERAL DIRECTOR Wm C March | | | | ADDRESS 928 E. North Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|----------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | X | | REG. NO. 70 1884 | |
| G-600 70 1884 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) GRAY, George Lee (GRAY) | | 2. DATE AND HOUR OF DEATH
2/11/70 11:20 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY
Maryland, Queen Anne
C. CITY OR TOWN
Centerville
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER
204 Kidwell Street | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/7/98 | 9. AGE (In years last birthday)
72 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Detroit, Mich. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
John Gray | | 14. MOTHER'S MAIDEN NAME
Lizzie Jones | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 8/18/42 - 5/20/43 | | 16. SOCIAL SECURITY NO.
219-07-7431 | | 17. INFORMANT
VA Hospital Records
ADDRESS
3900 Loch Raven Boulevard Balto., Md 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
CARCINOMA OF LUNG WITH BRAIN METASTASES
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 months | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Pulmonary, Tuberculosis, quiescent | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from February 3rd 19 70 to February 11th 19 70 that (I) (we) last saw the deceased alive on February 11th 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
David N. Marine | | 23B. DATE SIGNED
2/11/70 | | 23C. PHYSICIAN'S NAME (Type)
DAVID N. MARINE, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/16/1970 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
B. P. D#2 Centerville, Md | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. Kelly, Jr. | |
| 25C. FUNERAL DIRECTOR
James W. Kelly | | 25D. ADDRESS
Chester Town, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------------|---|--|---|---|
| W-452 70 1886 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1886 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | X REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) <u>JULIUS WILLIAMS</u> | | | 2. DATE AND HOUR OF DEATH
<u>2-10-70</u> <u>8:38</u> <u>A</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Edgemoor Nursing Home</u> | | | C. CITY OR TOWN <u>Lutherville</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | E. STREET AND NUMBER <u>1421 Bellona Ave.</u> | | |
| 5. SEX <u>male</u> | 6. RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 10, 1909</u> | 9. AGE (In years last birthday) <u>60</u> | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Burnsville, Va.</u> | |
| 13. FATHER'S NAME <u>John Williams</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary S. Miller</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-40-3382</u> | | 17. INFORMANT <u>Mrs. Virginia Williams</u> ADDRESS <u>1421 Bellona Ave</u> | |
| 18. <u>4-10-9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 1 This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. | | | (A) IMMEDIATE CAUSE <u>Recurrent myocardial infarct, second</u>
DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES | | | (B) <u>Unknow sclerotic cardiovascular dis</u> <u>7 yr</u>
DUE TO, OR AS A CONSEQUENCE OF: | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) _____ | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> 19 <u>70</u> to <u>Feb 10</u> 19 <u>70</u> that (I) <u>we</u> last saw the deceased alive on <u>Feb 8</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Frederick J. Vollmer MD</u> | | | | 23B. DATE SIGNED <u>2-10-70</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>FREDERICK J VOLLMER MD</u> | | | | 23D. ADDRESS <u>6100 YORK RD BALTO MD 21212</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/14/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park Arbutus</u> | |
| 24D. LOCATION (City, town, or county) <u>MD.</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>FEB 17 1970</u> | | 24F. NAME OF REGISTRAR <u>Charles E. Fisher</u> | |
| 24G. NAME OF REGISTRAR | | 24H. FUNERAL DIRECTOR <u>Joseph 4 Rumm</u> | | 24I. ADDRESS <u>2222 North Ave</u> | |

Department of Health

Department of Health
Public Health Service

1912

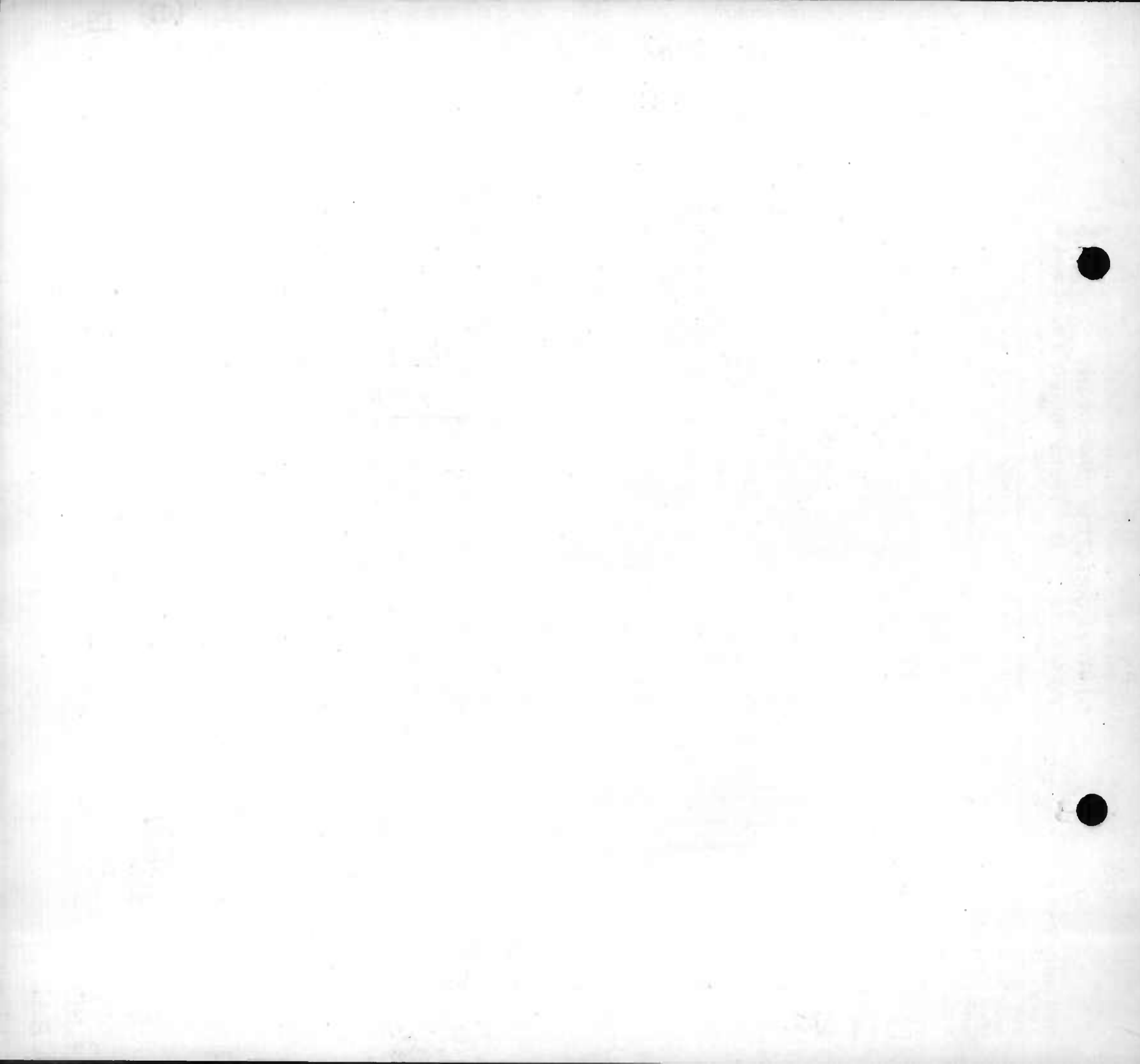
1912

Department of Health
Public Health Service

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| P-626 70 1887 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1887 | |
|--|---------------------|--|---|---|---|---|--|
| 1. NAME OF DECEASED
(Type or Print) Parker Georgia | | | | 2. DATE AND HOUR OF DEATH
2.10.70 12.30 a M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Lutheran Hospital
46 730 Ashburton St
Baltimore. MD. 21216 | | | | A. STATE
Baltimore. | | B. COUNTY
1501 Dukeland St | |
| | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
1501 Dukeland St. | | | |
| 5. SEX
Female | 6. RACE
N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-5-12 | 9. AGE (In years last birthday)
57 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | 10B. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Hospital Chart | | ADDRESS |
| 18. 582 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Azotemia with Acidosis
DUE TO, OR AS A CONSEQUENCE OF:
(B) Possible Chronic Renal disease
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2-8-70
2.10.70 | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
CVA with ① Hemiplegia. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2.8.1970 to 2.10.1970 , that (I) (we) last saw the deceased alive on 2.9.1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
P. Gnanas M.D. | | | | 23B. DATE SIGNED
2.10.70 | | | |
| 23C. PHYSICIAN'S NAME (Type) P. GNANES M.D. | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-17-70 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt Calvary Cem | | 24D. LOCATION (City, town, or county) (State)
Brooklyn Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Joseph Gross | | ADDRESS
22224 North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

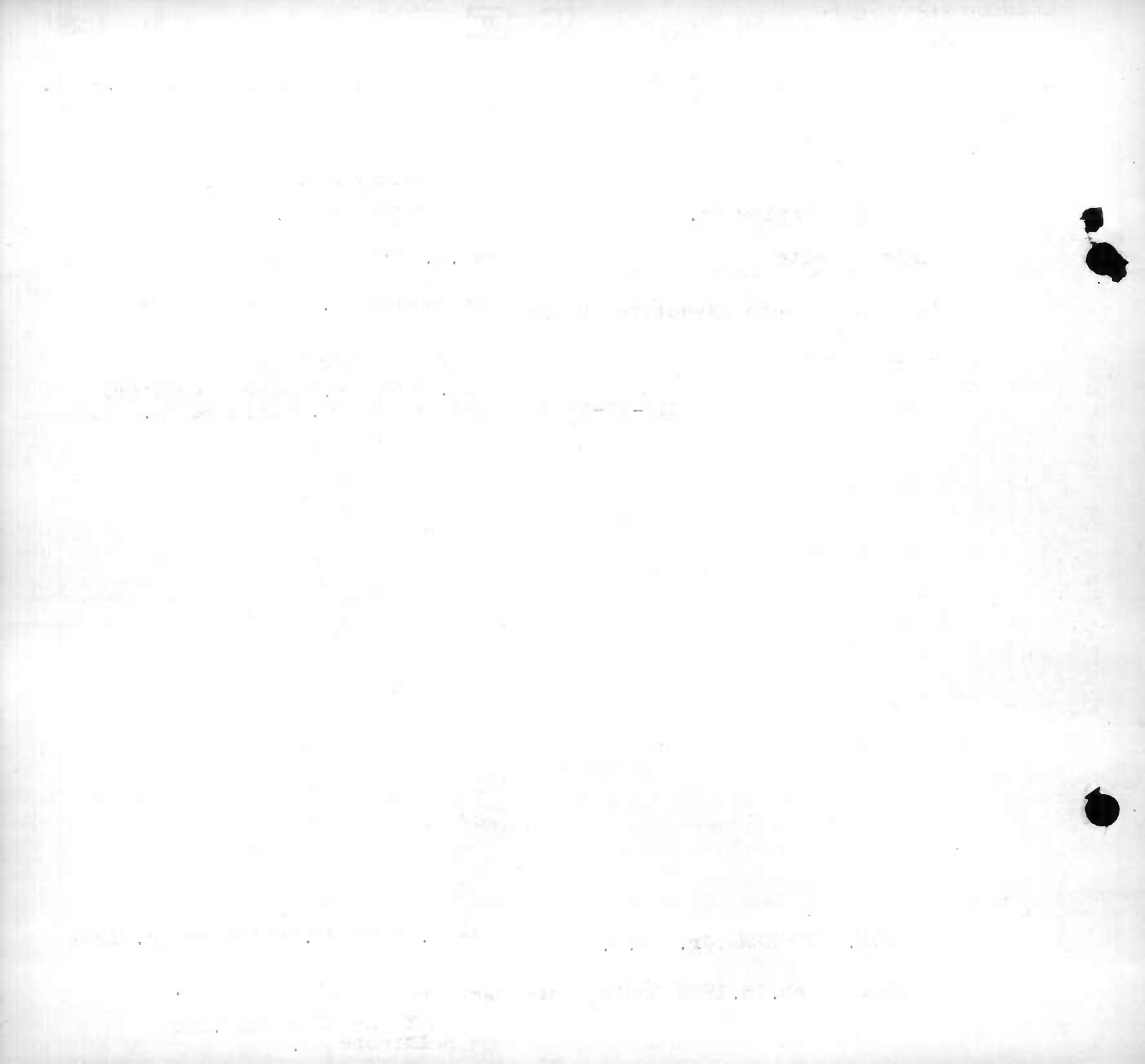
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1888 | |
|---|---------|--|------------------|---|---|
| K-620 70 1888 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | ELLENORA LORETTA KREIS | | Feb. 12. 1970 8:10 P. M. | |
| <div style="font-size: 2em; font-weight: bold; transform: rotate(-15deg); position: relative; top: -20px;"> CERTIFICATE AMENDED </div> | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | |
| | | 90 2-26-70
House in The Pines
5837 Belair Rd. | | Maryland
C. CITY OR TOWN Baltimore 21214 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2907 E. Strathmore Ave. | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Female | White | | Feb. 20. 1900 | 69 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Seamstress | | Retired | | Baltimore Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| John Adam Raab | | Johanna Feltsky Selske | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | 213-12-4727 | | Freeland Sr.
John R. Freeland Sr.-
2907 E. Strathmore Ave. 21214 | |
| <div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold;">MEDICAL CERTIFICATION</div> | | 18. CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | <div style="font-size: 1.5em;">months.</div> |
| | | (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<div style="font-family: cursive;"> Chronic Hypertension
 Chronic Bronchitis </div> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 9/16/1969 to 19 , that (I) (we) last saw the deceased alive on 2/12/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| <div style="font-family: cursive; font-size: 1.5em;">Albert B. Bradley</div> | | | | Feb. 13, 1970 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| ALBERT B. BRADLEY M.D. | | | | 4900 Belair Rd. Baltimore Md. 21206 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | Feb. 16. 1970 | | Loudon Park Cemetery | |
| | | | | Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 17 1970 | | Robert E. Taylor, M.D. | | HENRY SANDER & SONS, INC.
Baltimore Md. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 70 1889 |
|--|--|---|---|--|--|
| E-456
70 1889 | | 70 1889 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| JOHN ELMER | | February 16, 1970 | | 1.30 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| | | Maryland | | | |
| 102 Taplow Rd. | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | Baltimore 21212 | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | 102 Taplow Rd. | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | White | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Aug. 5. 1885 | 84 | Broadcast Radio Executive (WCBM) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Broadcast Radio Executive (WCBM) | | | | Baltimore Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | USA | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| John Elmer | | Elizabeth Birkhead | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | 217-07-4787 | | Mrs. George H. Roeder (Daughter)
102 Taplow Rd. Baltimore Md. 21212 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | Arteriosclerotic Cardiovascular Disease | | 20 years | |
| | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | 20 years | |
| ANTECEDENT CAUSES | | (C) Uremia | | 1 week | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | Congestive Heart Failure | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| no | | no | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1954 to 2/16 1970, that (I) (we) lost saw the deceased alive on 2/14 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| W. H. Townshend, Jr. | | | | 2/16/70 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| W. H. TOWNSHEND, Jr. M.D. | | 14 E. Eager St. Baltimore Md. 21202 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | Feb. 18. 1970 | Druid Ridge Cemetery | Baltimore Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 17 1970 | | Robert E. Sander, Jr. | | HENRY SANDER & SONS, INC
Baltimore Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------------|---|--|--|--|---|--|
| A-654 | | 70 1890 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1890 | |
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Edward George Arnold</u> | | | | 2. DATE AND HOUR OF DEATH
<u>Feb. 13, 1970</u> <u>3:30 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
<u>Md.</u> | | B. COUNTY
<u>Balto.</u> | |
| <u>University Hospital</u> | | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<u>951 Elmridge Ave.</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Aug. 1, 1919</u> | 9. AGE (in years last birthday)
<u>50</u> | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Cab Driver</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>E. G. Arnold</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Bertha?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>219-05-4212</u> | | 17. INFORMANT
<u>Clinical Record Brief.</u> | | ADDRESS | |
| 18. <u>238.1 + 1 250.9</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<u>Intra Cerebral Hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>Brain Tumor</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Hypertension Diabetes mellitus</u> | | | | | | | |
| 19A. DATE OF OPERATION
<u>12-12-70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Intracerebral Hemorrhage</u> | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-12-70</u> 19 <u>70</u> to <u>2-13</u> 19 <u>70</u> that (I) (we) lost saw the deceased alive on <u>2-13</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Donald P. Sickler M.D.</u> | | | | 23B. DATE SIGNED
<u>Feb 13, 1970</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Donald P. Sickler M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/17/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Baltimore Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 17 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Saker</u> | | 25C. FUNERAL DIRECTOR
<u>Ambrose Funeral Home, Balto. Co. Md.</u> | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1891 | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | REG. NO. | |
| SHELTON, Randolph L. | | 2/16/70 | | 10 ³⁰ AM M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | 1803 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
The Johns Hopkins Hospital | | A. STATE
Maryland | | C. CITY OR TOWN
Baltimore | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | B. COUNTY | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
Male | | 6. RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
7/4/21 | | 9. AGE (In years last birthday)
48 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Lessor | | | | RICHMOND VA | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
William Swerton | | 14. MOTHER'S MAIDEN NAME
Virginia Campbell | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
216-12-7602 | | 17. INFORMANT
Virginia Butts 95 Arlington Ave | |
| 18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Acute Myocardial Infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
HASCVD | | Many Years | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
32/12/70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
HASCVD & Bradycardia | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 2/11/70 to 2/16/70, that (I) (we) lost saw the deceased alive on 2/16/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
David J. Pierson M.D. | | 23B. DATE SIGNED
2/16/70 | | 23C. PHYSICIAN'S NAME (Type)
David J. Pierson M.D. | |
| 23D. ADDRESS
Johns Hopkins Hospital | | 23E. FUNERAL DIRECTOR
Marshall P. Hays 638 N. G. Street | | 23F. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/19/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt Auburn | |
| 24D. LOCATION (City, town, or county)
Baltimore | | 24E. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 24F. NAME OF REGISTRAR
Robert E. Taylor | |



70 1892

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1892

BIRTH NO.

| | | | | | |
|---|-------------------------|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) MAE BALDWIN | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> February 14, 1970 | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
February 14, 1970 12:15 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
Mercy Hospital (DOA) | | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 1206 | | | |
| 6. SEX
Female | 7. RACE
Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
4-30-23 | | 10. AGE (In years lost birthday)
46 | | E. STREET AND NUMBER
304 E. 20½ Street | |
| 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Roland Barden | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME
Janie Flower | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT ADDRESS
Mrs. Mattie Brown 327 E. 21st St. 21218 | |
| 19. E 890 X | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE Carbon monoxide poisoning
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) Conflagration
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
No | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
home | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?
304 E. 20½ Street 1206 | |
| 22D. TIME OF INJURY (APPROX.)
2-14-70 11:53 A.m. | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Fire apparently due to children playing with matches | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Charles S. Springate | | M.D.
Charles S. Springate, M.D. | | DATE SIGNED
February 15, 1970 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-18-1970 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
1735 Harford Ave. 21213 Marshall W. Jones, Jr. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1893 |
|---|--|--|--|--|
| BIRTH NO. 70 1893 | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) THOMSEN SAMUEL LOCKE SR. | | 2. DATE AND HOUR OF DEATH
FEBRUARY 16th 1970 1:28 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
44 UNION MEMORIAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 2711 | | |
| 5. SEX MALE 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 8. DATE OF BIRTH 08-25-86 | | 9. AGE (In years last birthday) 83 | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME FRANCIS JORDAN THOMSEN | | |
| 14. MOTHER'S MAIDEN NAME CLARA LOCKE | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES U.W.I. | | |
| 16. SOCIAL SECURITY NO. 215-10-5758A | | 17. INFORMANT KATHERINE T. EDMUNDS ADDRESS same as above. | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
412.41
Pneumonia
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from February 15th 1970 to February 16th 1970 , that (I) (we) last saw the deceased alive on February 16th 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE J. Cabrera | | 23B. DATE SIGNED 2/16/70 | | 23C. PHYSICIAN'S NAME (Type) J. CABRERA |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremated | | 24B. DATE 2/17/70 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 17 1970 | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd Balto., Md. 21212 | | |

UNION MEMORIAL HOSPITAL

MALE WHITE

RETIRED

FRANCIS JORDAN THOMSEN

BALTIMORE

9 BAYVIEW ROAD

08-25-24

MARYLAND

CARR LOCKS

KATHERINE T EDWARDS

Presumably

Administrative correspondence

no

February 1970 to February 1971

2/1/70

no

UNION MEMORIAL HOSPITAL

T. CROGER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 1894

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

70 1894

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Mary Kirby Williamson Chew

2. DATE AND HOUR OF DEATH

Feb. 16, 1970

8 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 4202 Roland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4202 Roland Ave.

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

7-12-1880

9. AGE (in years last birthday)

89

10. Under 1 Yr. 11. Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Fred Williamson

14. MOTHER'S MAIDEN NAME

Emma Duncan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-07-2374

17. INFORMANT

Emily S. Chew

ADDRESS

Same

18. 7-12-11

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE *Hypertensive arterio-sclerotic heart disease*
DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

16 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *4 October* 19 *54* to *16 February* 19 *70* that (I) (we) last saw the deceased alive on *12 February* 19 *70* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John W. Barnaby

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

17 Feb 70

23C. PHYSICIAN'S NAME (Type)

John W. Barnaby

M.D.

23D. ADDRESS

1652 E. Belvedere Ave., Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-19-70

24C. NAME OF CEMETERY OR CREMATORY

West River-Christ Church

24D. LOCATION

(City, town, or county)

(State)

West River A.A.Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 17 1970

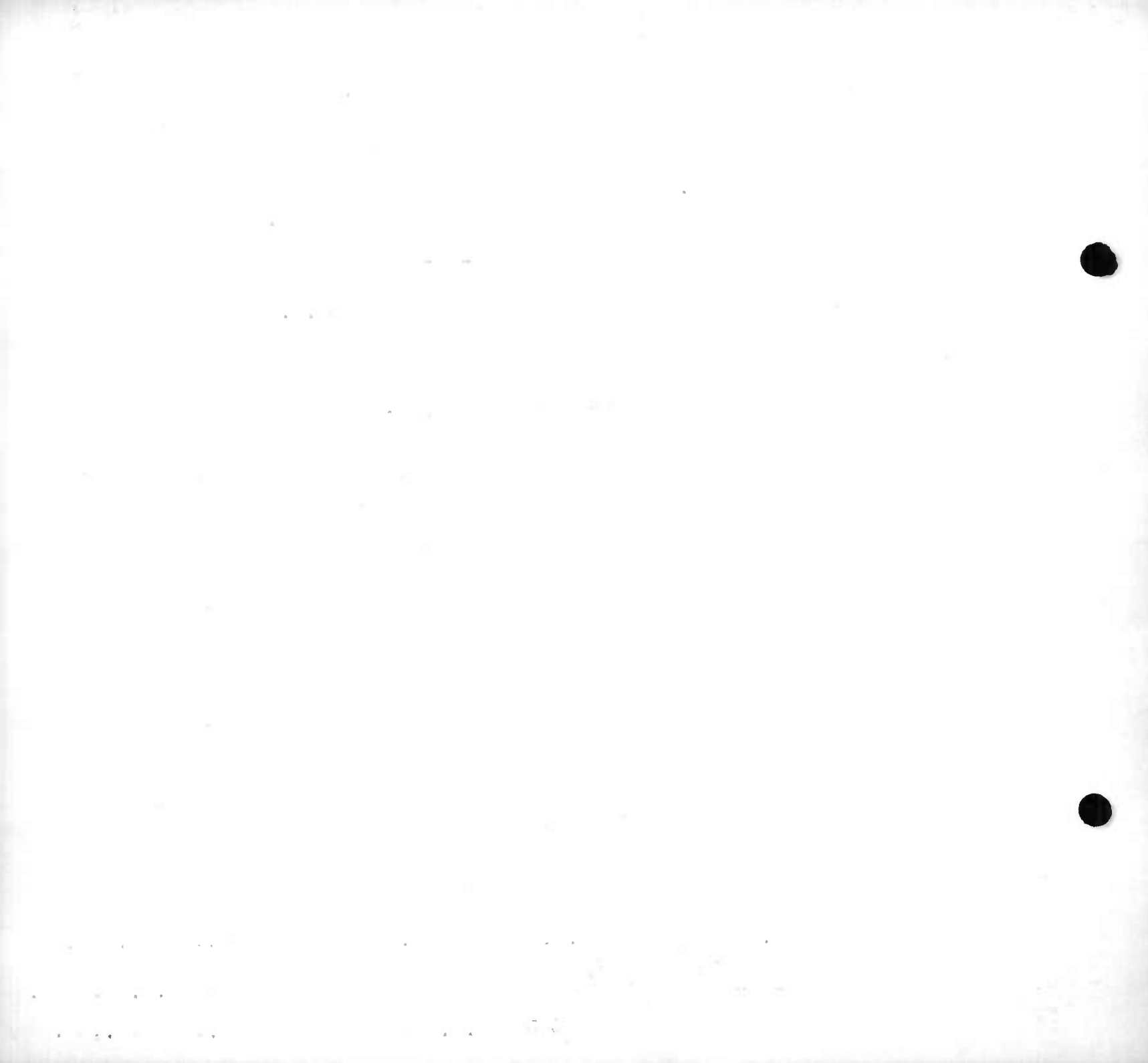
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co., Balto., Md.

ADDRESS



F-460¹

70 1895

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 1895

BIRTH NO.

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) MARION LEE FULLER | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> February 14, 1970 | | Month Day Year Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
LUTHERAN HOSPITAL (DOA) | | 3. DATE PRONOUNCED DEAD
February 14, 1970 | | Manth Day Year Hour
5:00 P. M. | |
| 6. SEX
Female | | 7. RACE
Negro | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH
1-26-24 | | 10. AGE (In years lost birthday)
46 | | 11. BIRTHPLACE (State or foreign country)
Norfolk Va | |
| 12. CITIZEN OF
WHAT COUNTRY? | | 13. FATHER'S NAME
Clarence Lee | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | |
| 15. MOTHER'S MAIDEN NAME
Shene Jones | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give word or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
Clarence Lee | | ADDRESS
2004 Woodbrook Ave | | 19. 4319 | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Intracerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) _____
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.) | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23.
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL EXAMINER'S NAME (Type)
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
February 15, 1970 | |
| ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/19/70 | | 24C. NAME OF CEMETERY or CREMATORY
Arbutus M. Park | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | |
| 25C. FUNERAL DIRECTOR
V. Brooks Ruggold | | ADDRESS
1463 N. Cary St | | | |

1935

1935

AMERICAN UNIVERSITY OF THE EAST

January 1, 1935

January 1, 1935

January 1, 1935

January 1, 1935

January 1, 1935

January 1, 1935

January 1, 1935

January 1, 1935

January 1, 1935

January 1, 1935

January 1, 1935

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January 1, 1935

January 1, 1935

January 1, 1935

January 1, 1935

January 1, 1935

H-536

70 1896

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1896

BIRTH NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) DOLETHA HENDERSON | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> February 14, 1970 | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
February 14, 1970 1:25 A.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
OR INSTITUTION
2968 Cherryland Rd. | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 2562 | | | |
| 6. SEX
Female | 7. RACE
Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 9. DATE OF BIRTH
2-13-14 | 10. AGE (In years last birthday)
56 | 11. BIRTHPLACE (State or foreign country)
NEWBERN, N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HENRY HENDERSON | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 15. MOTHER'S MAIDEN NAME
Ada Brady | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO.
— | | 18. INFORMANT
Mrs CATHERINE HALL | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
180X I
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
ANTECEDENT CAUSES
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (A) IMMEDIATE CAUSE Carcinoma of cervix
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION
O | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
No | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Springate, M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 2-14-70 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/17/70 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR
Charles R. Law | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| | | | | ADDRESS
802 Madison Ave | |

ACADEMIC RECORD

PERCENTAGE

VALLEY PARK, CT

1
H-400

BALTIMORE CITY HEALTH DEPARTMENT

70 1897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1897

BIRTH NO.

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print)
ELLIS HALL | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> Month Day Year Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
625 N. Paca St. 3rd floor | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
2 15 70 12:30 P.M. | |
| 6. SEX
Male | | 7. RACE
Negro | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
July 28, 1911 | | 10. AGE (In years last birthday)
59 58 | |
| 11. BIRTHPLACE (State or foreign country)
Newbern, N. C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
Catherine Hall - 2910 Cherryland Rd. | | ADDRESS | |

| | | | |
|---|--|---|--|
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Hypertensive cardiovascular disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE: <i>Russell S. Fisher</i> M.D.
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED: 2-16-70 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-17-70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
Charles R. Law | | ADDRESS
802 Madison Ave. | |

ACADEMIC BOND

240 DOLLARS

PAID BY D. PERRO

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

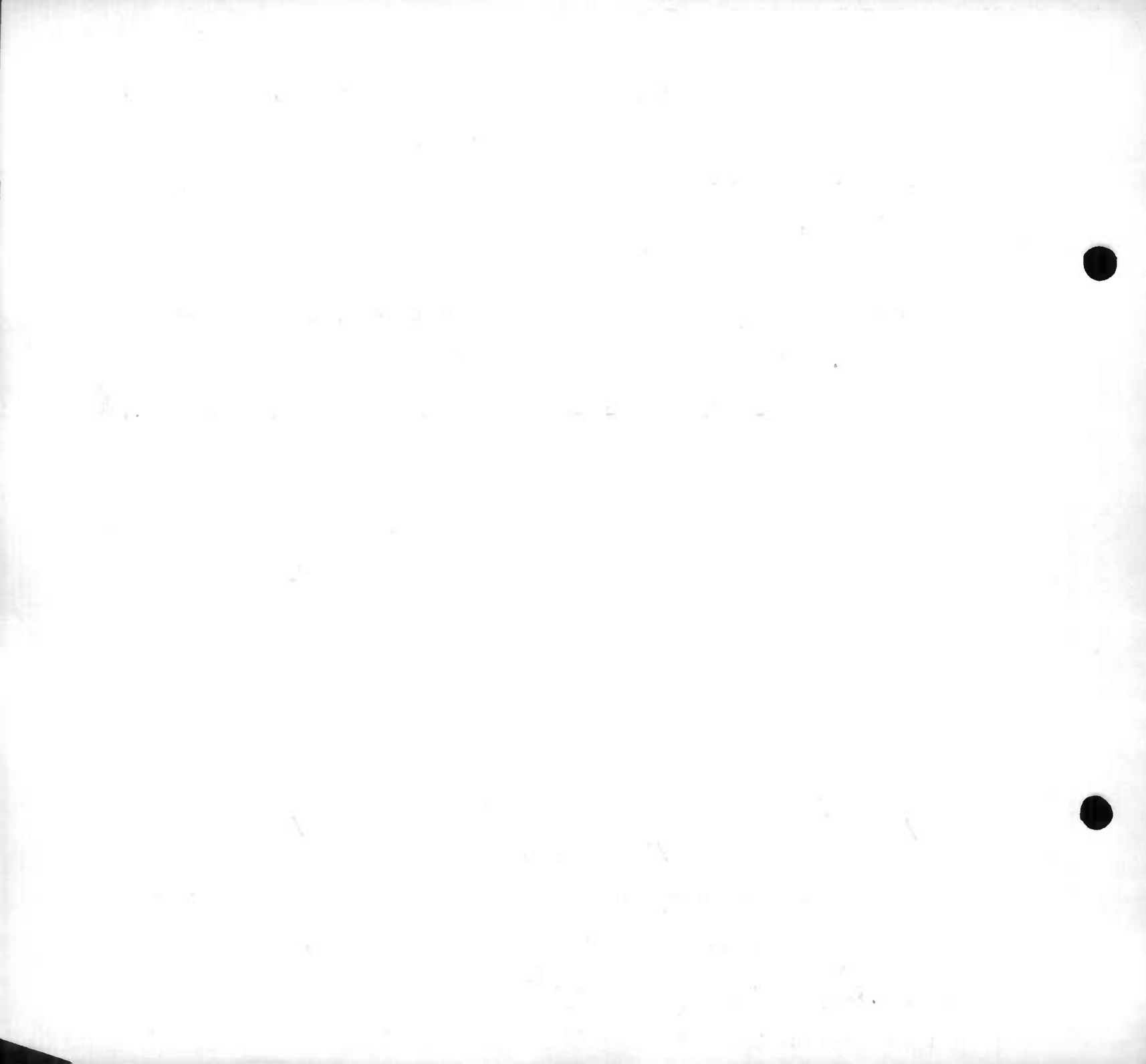
1929

1930

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 70 1898 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | 70 1898 | |
|---|--|--|--|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | WILSON, Edward Maurice | | February 12, 1970 2:25 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| 23 Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Md 21218 | | Maryland Balto. 5300 | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| Male | | Negro | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| Porter | | | | 4/21/08 | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 9. AGE (in years last birthday) | |
| Philadelphia, Pa | | USA | | 61 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| Edward W. Wilson | | Mary Kisker | | Yes 8/17/43 - 10/1/45 | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMATION | | ADDRESS | |
| 15009-4751 | | VAH Baltimore Records | | 3900 Loch Raven Boulevard, Balto., Md 21218 | |
| 18. CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE | | Endotoxic shock | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | DUE TO, OR AS A CONSEQUENCE OF: | | 2 days | |
| ANTECEDENT CAUSES | | (B) Pneumonia | | 7 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from February 1st 19 70 to February 12th 19 70 that (1) (we) last saw the deceased alive on February 12th 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Ronald S. Pototsky M.D. | | 2/13/70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| RONALD S. POTOTSKY M.D. | | 3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 2-18-70 | | Baltimore National | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR | | ADDRESS | |
| Baltimore, Maryland | | Charles R. Law | | 802 Madison Ave. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 17 1970 | | Robert E. Taylor M.D. | | Charles R. Law | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1899</u> | |
|--|----------------------|--|---------------------------------|--|--|
| BIRTH NO. <u>70 1899</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Applearth Elsie</u> | | 2. DATE AND HOUR OF DEATH
<u>2-15-70 - 7AM</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

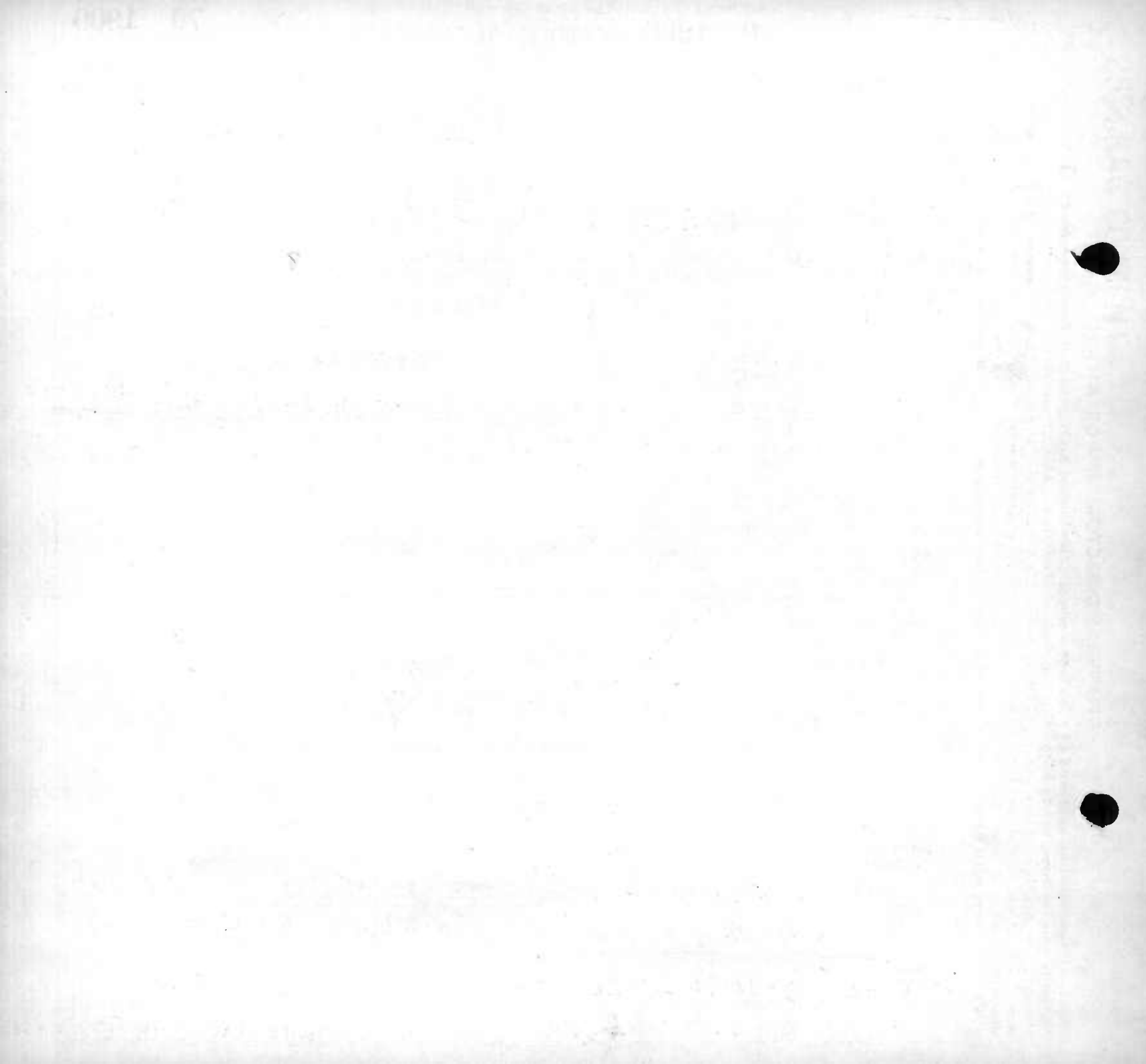
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>Harbor View ncc</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>2003</u>
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>207 HATHISON ST.</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-19-96</u> | 9. AGE (in years last birthday) <u>73</u> | 10. Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>George</u> | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>213-036712</u> | | 17. INFORMANT ADDRESS <u>Mr. Kanelly - nephew</u> | |
| 18. <u>41231</u> CAUSE OF DEATH | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF: | | <u>2/13/70</u> | |
| ANTECEDENT CAUSES | | (B) <u>arteriosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF: | | <u>years</u> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) <u>arteriosclerotic generalized</u> | | <u>years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | <u>cholecystectomy</u> | | <u>Nov 30 1969</u> | |
| 19A. DATE OF OPERATION <u>Nov 1969</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>cholecystitis</u> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (If yes, notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/28 1969</u> to <u>2/15 1970</u> that (I) (we) last saw the deceased alive on <u>2/15 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Al Ma...</u> | | 23B. DATE SIGNED <u>2/15/70</u> | | 23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MAECHT MD</u> | |
| 23D. ADDRESS <u>2 E Red St Balto Md 21202</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2-18-70</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>LOUDON PK.</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 17 1970</u> | |
| 25B. NAME OF REGISTRAR <u>Walter E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>GEO. L. SCHWAB INC.</u> | | 25D. ADDRESS <u>2101 FRED'K AVE</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1900 | |
|---|---|--|--|--|---|
| BIRTH NO. 70 1900 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Dietzel, Anna | | 2. DATE AND HOUR OF DEATH
2-17-70 6⁴⁵ AM M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Anne Arundel Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Melchor Nursing Home | | C. CITY OR TOWN
BALTO. | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| E. STREET AND NUMBER
219 MONROE ST. | | | | | |
| 5. SEX
Female | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-23-80 | 9. AGE (In years last birthday)
89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Germany | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Aschenback | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No None. | | 16. SOCIAL SECURITY NO.
215-09-4085 | | 17. INFORMANT
FRANK Dietzel | |
| 18. 412.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Cardio-Vascular Disease | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Arteriosclerotic Cardio-Vascular Disease
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Several years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 68 19 to Feb. 19 70 , that (I) (we) last saw the deceased alive on Feb. 16 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Loy M. Zimmerman M.D. | | 23B. DATE SIGNED
2/17/70 | | 23C. PHYSICIAN'S NAME (Type)
Loy M. Zimmerman M.D. | |
| 23D. ADDRESS
3202 Hartford Rd. Baltimore, Md. | | | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
BURIAL | | 24B. DATE
2-20-70 | | 24C. NAME OF CEMETERY or CREMATORY
LOUDON PK. | |
| 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
GEO. L. SCHWAB INC. | |
| ADDRESS
2101 FRED'K AVE | | | | | |



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HOWARD FRANKLIN LEE

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ 2 13 70 12:40 a

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital D.O.A.

3. DATE PRONOUNCED DEAD Month Day Year Hour
February 13, 1970 12:40 a

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 1303

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Aug. 8, 1947

10. AGE (In years lost birthday)

22

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

2503 Francis St.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Howard F. Lee, Sr.

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Georgetta Elsie Gilbert

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no

17. SOCIAL SECURITY NO.
214-50-5317

18. INFORMANT

ADDRESS

Georgetta E. Green 2503 Francis St.

19. E965 IX

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Gunshot wound of the head

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

3732 Garrison Ave. 2798

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
2 13 70 12:12

22E. INJURY OCCURRED WHILE AT WORK ☐

NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject found in gutter, shot

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Tsidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/17/70

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

FEB 17 1970

25B. NAME OF REGISTRAR

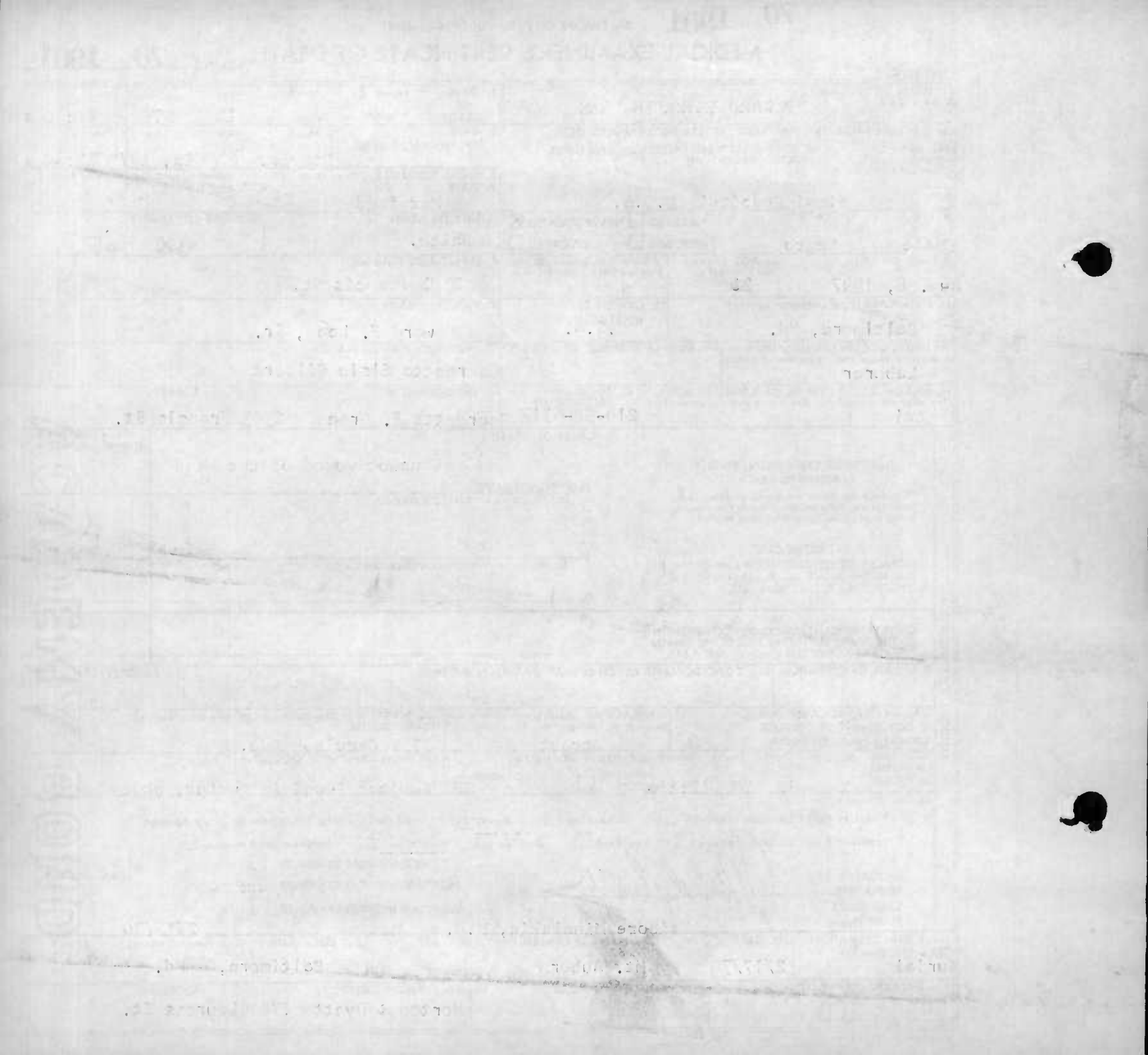
John E. Pabst, Jr.

25C. FUNERAL DIRECTOR

Morton & Dyett

ADDRESS

1701 Laurens St.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1902

BIRTH NO. 70-01782

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
SHARON PAYNE | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year
February 14, 1970
Hour M.
3:05 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Lutheran Hospital 3-12-70 (DOA) | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
February 14, 1970 3:05 P.M. | |
| 6. SEX
Female | | 7. RACE
Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 1304 | |
| 9. DATE OF BIRTH
2 | | 10. AGE (In years lost birthday) weeks
2 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Infant | | 14B. KIND OF BUSINESS OR INDUSTRY
N/a | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 17. SOCIAL SECURITY NO.
-0- | |
| 18. INFORMANT
Mr. Joseph Payne | | 15. MOTHER'S MAIDEN NAME
Babar Ann Payne (Barbara) | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Early meningitis
Sudden death in infancy--
DUE TO, OR AS A CONSEQUENCE OF:
(A) IMMEDIATE CAUSE
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | 20. DATE OF OPERATION
2 | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
Yes | | 22. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22F. HOW DID INJURY OCCUR? | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Springate, M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED February 15, 1970 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/7/70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Mount Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | | 25D. ADDRESS
1701 Laurens Street | |

Letter from M.E.'s office

3-12-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-152 70 1903 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1903 | |
|---|-------------------|---|-------------------------------|---|---|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MARY ROBINSON | | 2/14/70 12:05 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
Maryland | | B. COUNTY
2716 | |
| 00 4644 Pall Mall Rd. | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
4644 Pall Mall Road | | | |
| 5. SEX
Female | 6. RACE
Negrid | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/19/1901 | 9. AGE (In years last birthday)
68 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Edgefield, S. Carolina | |
| 13. FATHER'S NAME
Unk. | | 14. MOTHER'S MAIDEN NAME
Unk. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Annie Mae Hall | |
| | | | | ADDRESS
4644 Pall Mall Road | |
| 18. 43391
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Recent Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF:
(B) Cerebral Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF:
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks
1 yr | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 30 1968 to Feb 14 1970 that (I) (we) last saw the deceased alive on Feb 11 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Roland T. Smoot, M.D. | | 23B. DATE SIGNED
2/16/70 | | 23C. PHYSICIAN'S NAME (Type)
ROLAND T. SMOOT M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-19-70 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt. Olive Bapt. Ch. Cem. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | 25B. NAME OF REGISTRAR
Chas E. Taylor, R.D. | | 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | |
| | | | | ADDRESS
1701 Laurens Street | |

2009

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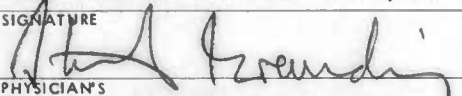
1000

1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

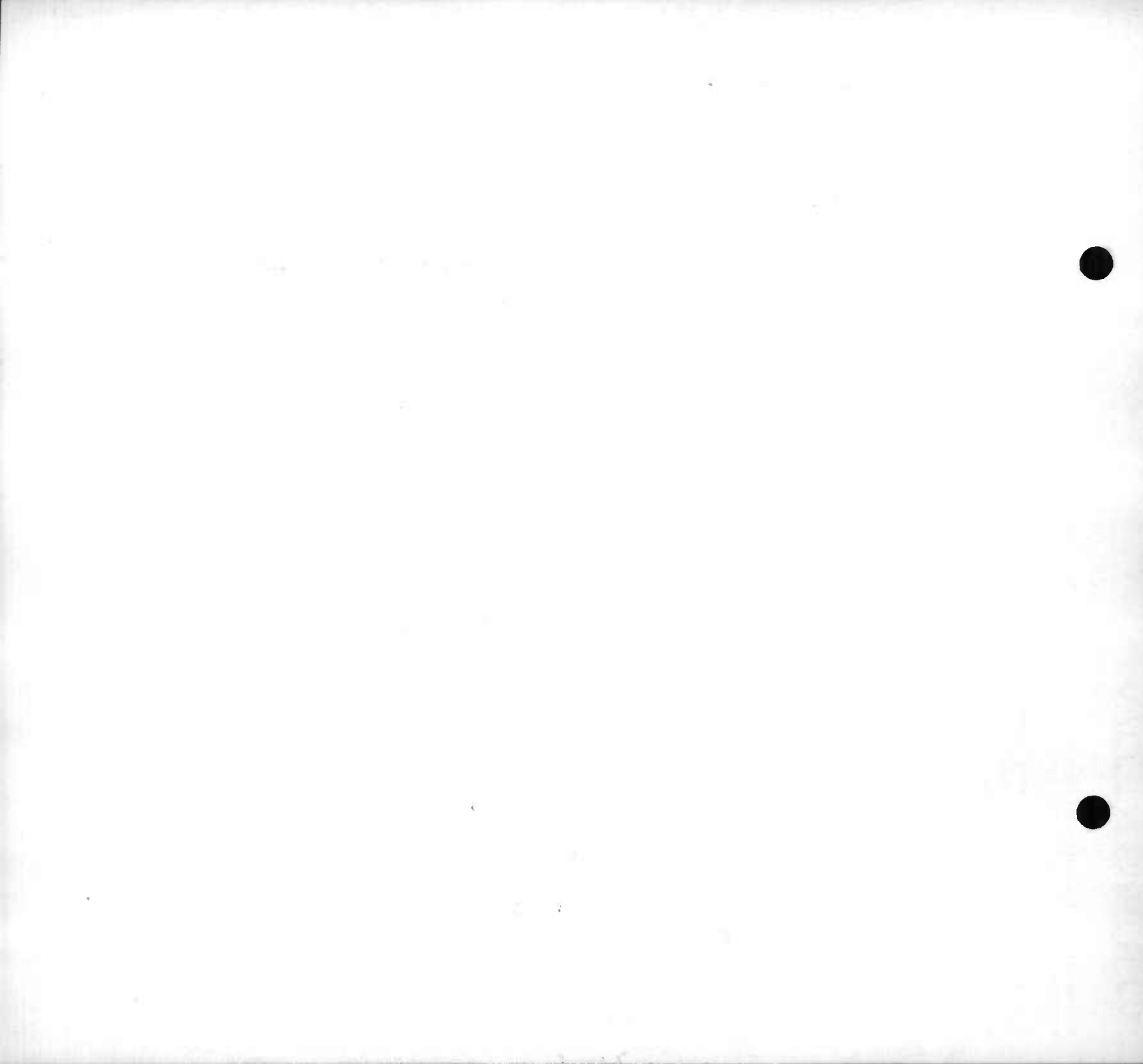
| Baltimore City Health Department | | | | REG. NO. | |
|---|--|---|---|---|---|
| F-462 70 1904 | | | | 70 1904 | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) FLOWERS, James Edward | | | 2. DATE AND HOUR OF DEATH
2/13/70 10:47A M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 1403 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
23 Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
5/26/08 61 | | 9. AGE (In years last birthday)
61 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Self employed | | | 10B. KIND OF BUSINESS OR INDUSTRY
Grocery store | | 11. BIRTHPLACE (State or foreign country)
Scottsville, Va |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
Samuel Flowers | | |
| 14. MOTHER'S MAIDEN NAME
Mary Cottrell | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 12/27/43 - 8/29/44 | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMATION
VA Hospital Records Records
3900 Loch Raven Blvd., Balto., Md 21218 | | |
| 18. 441.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
DISSECTION OF AORTA w/HEMO-PERICARDIUM (CARDIAC TAMPONADE) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
YES | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 13th 1970 to February 13th 1970 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 13th 1970 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)
STEWART GRANDIS, MD | | | | 23B. DATE SIGNED
2-15-70 | |
| 23D. ADDRESS
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | | 23E. FUNERAL DIRECTOR
MORTON & DYETT FUNERAL HOMES | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/17/70 | | 24C. NAME of CEMETERY or CREMATORY
Carver Mem. Park Cem. | |
| 24D. LOCATION
Laurel, Maryland | | 24E. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | | |
| 24F. NAME OF REGISTRAR
Charles E. Taylor, MD | | 24G. ADDRESS
1701 Laurens St. | | | |

W. H. Lawrence

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> H-400 70 1905 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> BIRTH NO. REG. NO. 70 1905 </div> | | | |
| 1. NAME OF DECEASED
(Type or Print) HALL ALICE | | 2. DATE AND HOUR OF DEATH
2. 15. 70 6.15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
39 Provident Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE md.
B. COUNTY 1502
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1815 Baker Street | |
| 5. SEX Female
6. RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-11-20
9. AGE (In years last birthday) 49 | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Julius Hall | | 14. MOTHER'S MAIDEN NAME Elmira Hall | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Pearl Jones | | ADDRESS 1815 Baker St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
486X-2150.9 | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | Arthritis Rheitis | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2. 15. 1970 to 2. 15. 1970 that (I) (we) last saw the deceased alive on 2. 15. 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE M. J. Shafi | | 23B. DATE SIGNED 2. 15. 70. | |
| 23C. PHYSICIAN'S NAME (Type) M. J. SHAFI | | 23D. ADDRESS Provident Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/19/70 | |
| 24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT. FEB 17 1970 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Morton E. Dyett F.H. | | ADDRESS 1701 Laukens St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1906 | |
|--|-------------------------|---|-----------------------------------|---|---|
| 1. NAME OF DECEASED
(Type or Print) EMERSON PARKER | | 2. DATE AND HOUR OF DEATH
FEB., 15, 1970 10:40 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
LUTHERAN HOSPITAL OF MD.
730 ASHBURTON STR.
BALTO., MD., 21216 | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland
B. COUNTY 1601
C. CITY OR TOWN Balto.
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER
1231 W. Lafayette Ave. | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-9-99 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Hottsburg, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Arthur Parker | | | |
| 14. MOTHER'S MAIDEN NAME
Augusta Parker | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO. | | | |
| 16. SOCIAL SECURITY NO.
212-07-8546 | | 17. INFORMANT ADDRESS
Mrs Lorraine Brooks 1513 Edmondson | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
THORACIC EXTRADURAL METASTATIC CARCINOMA
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
II
DIABETES MELLITUS | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DEC. 2, 1969 to FEB. 15, 1970
that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEB. 15, 1970 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Christos S. Dibranos, M.D.
DEGREE | | | | 23B. DATE SIGNED
FEB., 15, 1970 | |
| 23C. PHYSICIAN'S NAME (Type)
CHRISTOS S. DIBRANOS, M.D.
DEGREE | | | | 23D. ADDRESS
730 ASHBURTON STR.
BALTO., MD. 21216 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/19/70 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Mem. Park | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 17 1970 | | | |
| 25B. NAME OF REGISTRAR
John E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Horton & Dyett F.H. 1701 Laurens St. | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

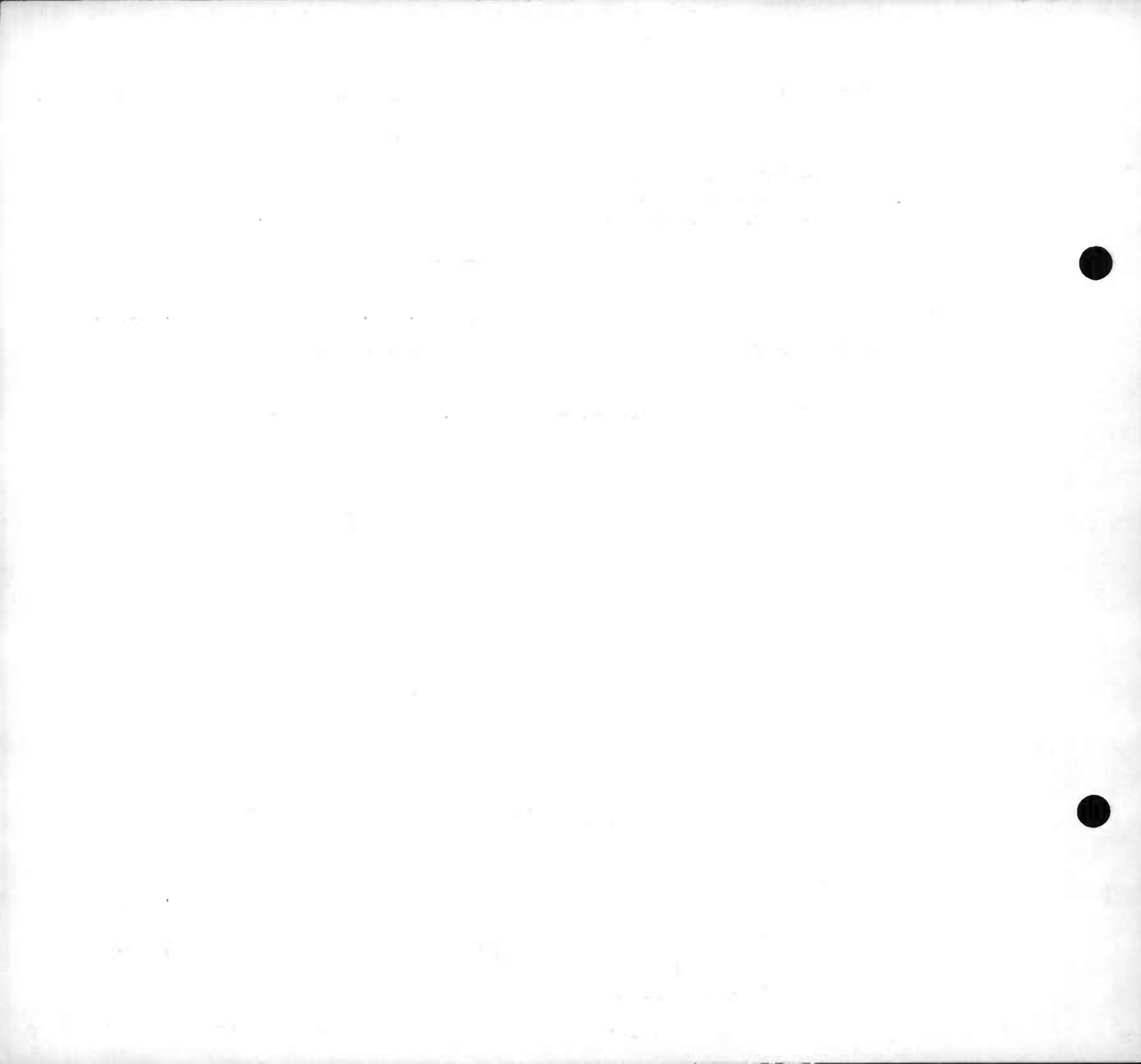


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>70 1908</u> | |
|---|-------------------------|--|------------------------------------|--|--|
| J-525 70 1908 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Johnson, Ulysses</u> | | 2. DATE AND HOUR OF DEATH
<u>2-14-70</u> <u>1:45</u> P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

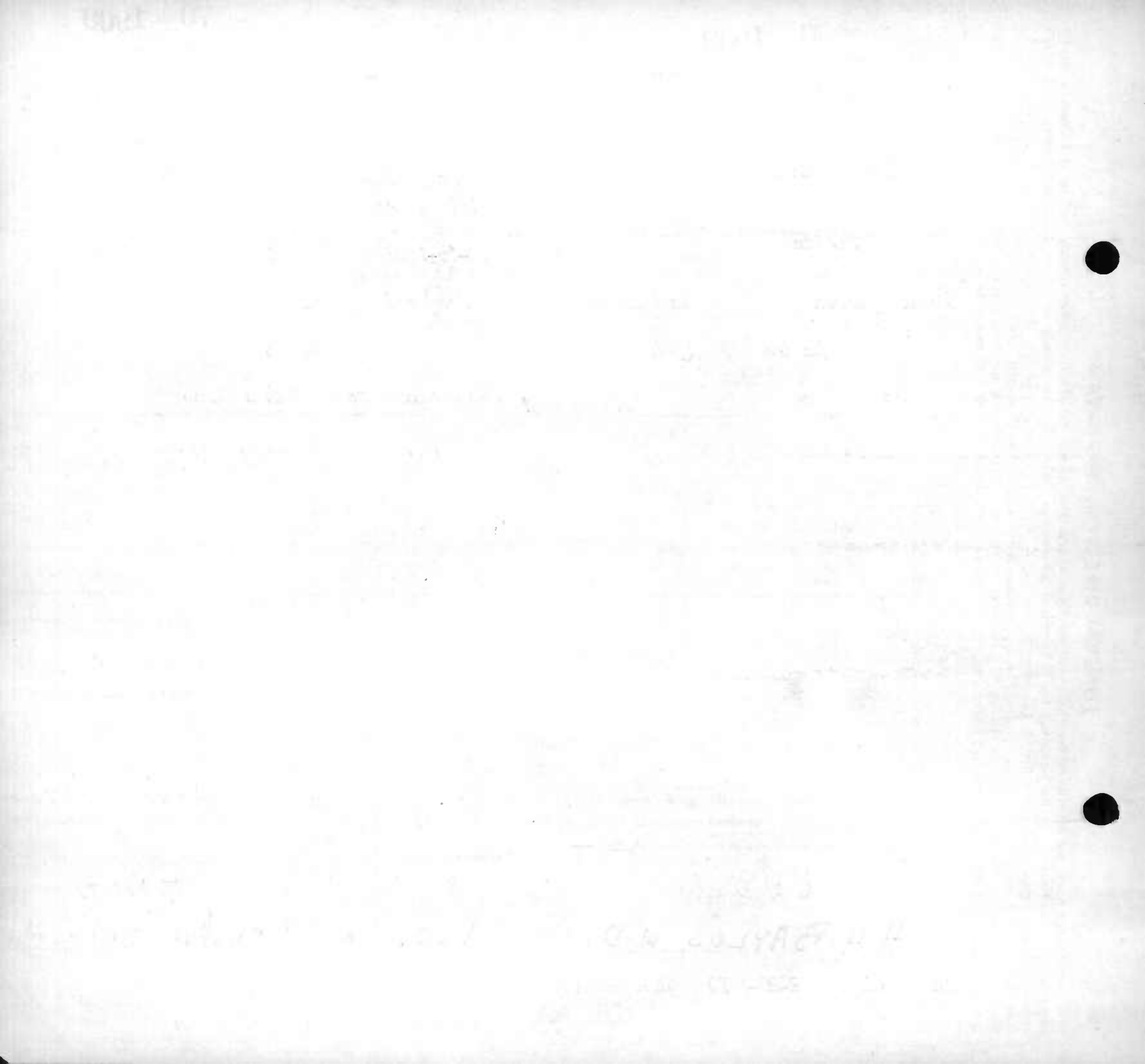
FULL NAME OF HOSPITAL OR INSTITUTION
<u>39 Provident Hospital</u>
<u>1514 Divison Street</u>
<u>Baltimore, Maryland 21217</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>1504</u>
C. CITY OR TOWN <u>Baltimore</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>2430 Reistertown Rd.</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>5-24-16</u> | 9. AGE (in years last birthday) <u>53</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unemployed</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Balto. Md.</u> | |
| 13. FATHER'S NAME
<u>Ulysses Johnson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Annie Bradford</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> <u>9/XX Dec 42</u> <u>14 Feb 46</u> | | 16. SOCIAL SECURITY NO.
<u>220-09-6433</u> | | 17. INFORMANT
<u>Mrs. Annie Johnson-Mother</u> ADDRESS <u>Same</u> | |
| 18. <u>410.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Myocardial Infarction</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Heart Failure</u> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-14-70</u> 19 to <u>2-14-70</u> 19 that (I) (we) last saw the deceased alive on <u>2-14-70</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>V. Javier</u> DEGREE | | | | 23B. DATE SIGNED
<u>Feb. 16, 1970</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>V. JAVIER</u> | | 23D. ADDRESS
<u>1514 Divison Street Baltimore, Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/18/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Baltimore National Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 17 1970</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Talley, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Morton & Dyett Funeral Homes, Inc.</u> | | | |
| 25D. ADDRESS
<u>1701 Laurens St., Balto., Md.</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1909 | |
|---|--|---|--|--|--|
| BIRTH NO. 70 1909 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) John H Cook | | 2. DATE AND HOUR OF DEATH
2-15-1970 2:30 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
1518 W Pratt St | | A. STATE Md | | B. COUNTY 1902 | |
| 5. SEX Male | | 6. RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 10-16-1908 | | 9. AGE (In years last birthday) 67 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Cleaner | | 10B. KIND OF BUSINESS OR INDUSTRY Sanitation | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Charles J Cook | | 14. MOTHER'S MAIDEN NAME Brooks | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no no | | 16. SOCIAL SECURITY NO. 213 09 6851 | | 17. INFORMANT Mrs Margaret Brophy 124 S Gilmore | |
| 18. 410.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction | | immediate | |
| ANTECEDENT CAUSES | | (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic CV Disease | | 5 yrs | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Hypertension | | 10 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1967 to Jan 1970, and that (I) (we) last saw the deceased alive on 15 Jan 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. H. Bayliss | | 23B. DATE SIGNED 16 Feb 70 | | 23C. PHYSICIAN'S NAME (Type) H. H. BAYLUS, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-20-1970 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk Cem | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md | | 25A. DATE REC'D BY HEALTH DEPT. FEB 17 1970 | | 25B. NAME OF REGISTRAR Robert E. Bailey, M.D. | |
| 25C. FUNERAL DIRECTOR Thomas J. Kenny, Inc 1600 Hollins | | ADDRESS | | | |

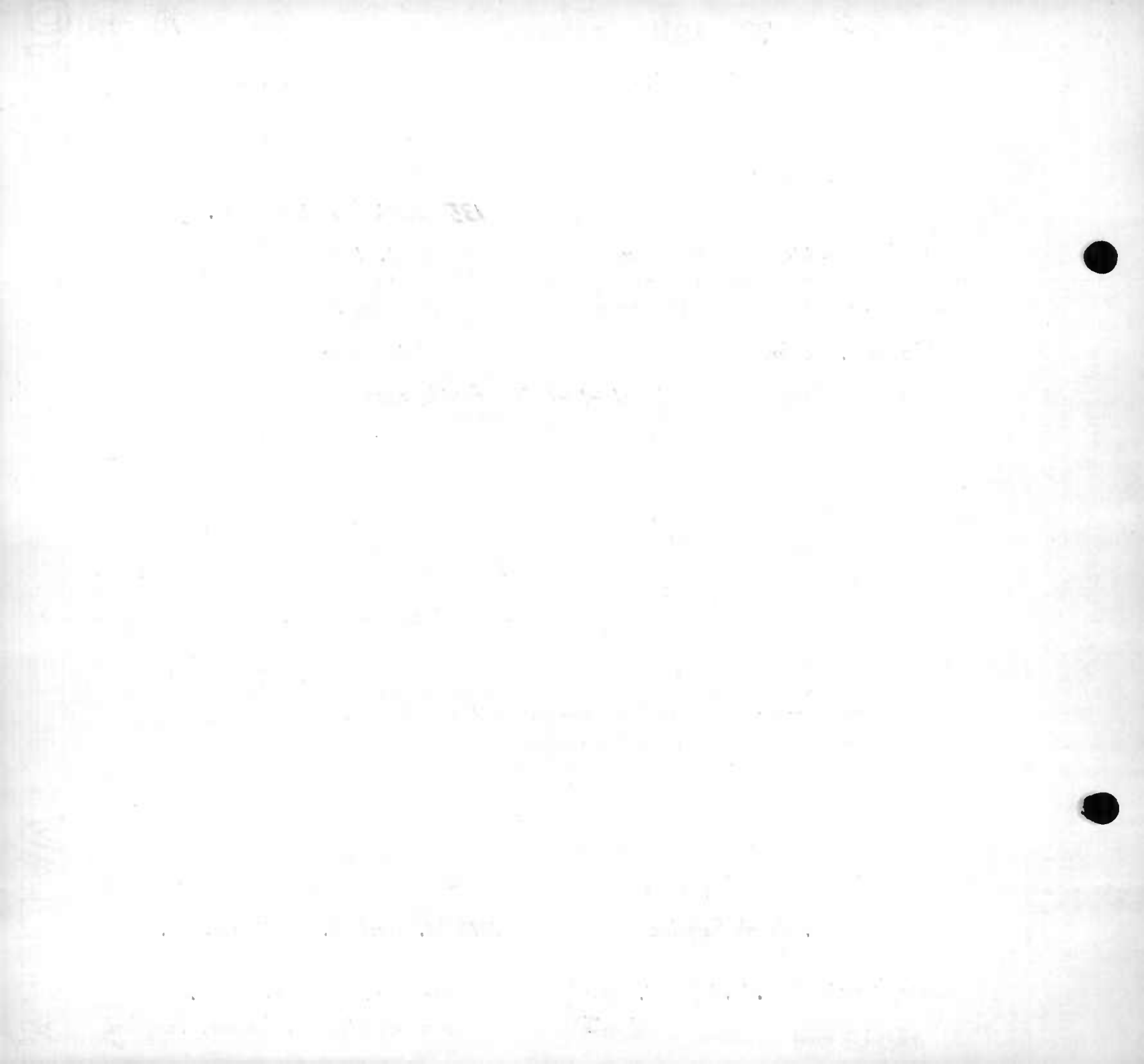


FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|--|--|--|--|--|---|--|
| 70 1910 <i>E-400</i> | | | | | 70 1910 | | | | |
| BIRTH NO. | | | | | REG. NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Annie Amelia Elya</i> | | | | | 2. DATE AND HOUR OF DEATH
<i>February 10, 1970</i> <i>2⁵⁰ P.M.</i> | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>Long Green Nursing Home</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN <i>Towson</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>135 Versailles Circle Apt. E</i> | | | | |
| 5. SEX
<i>Female</i> | 6. RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>August 21, 1890</i> | 9. AGE (In years last birthday)
<i>79</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Homemaker</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Pennsylvania</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Thomas B. Kellow</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Elsie Heysed</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>215-18-1807</i> | | 17. INFORMANT
<i>Family records</i> | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>412.41</i>
<i>Pneumonia due to pneumonia</i>
<i>Pneumonia</i> | | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>CVA & right hemiparesis</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Two months</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>As CVD</i> | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<i>As CVD</i> | | | (C) <i>Two months</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<i>As CVD & CVA + right hemiparesis</i> | | | | | | | | <i>Two months</i> | |
| 19A. DATE OF OPERATION
<i>0</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/12 1959</i> to <i>2/10 1970</i> , that (I) (we) last saw the deceased alive on <i>2/7 1970</i> and that is (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>J. Frank Supplee, III</i> | | | | | 23B. DATE SIGNED
<i>2/12/70</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>J. Frank Supplee III</i> | | | | | 23D. ADDRESS
<i>1010 St. Paul St., Baltimore, Md.</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | |
| <i>Removal/Burial Feb. 13, 1970 St. John's Reformed Cemetery, Bangor, Penna.</i> | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 17 1970</i> | | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>John Burns' Sons, Towson, Maryland</i> | | | ADDRESS | |



1

W-251 70 1911 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. REG. NO. 70 1911

1. NAME OF DECEASED (Type or Print) KENNETH WEISSENBORN

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour February 14, 1970 M.

3. DATE OF DEATH Pronounced Dead Month Day Year Hour February 14, 1970 8:23 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital (DOA)

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE New Jersey B. COUNTY Monmouth V-27

6. SEX Male 7. RACE White 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Shrewsbury D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH 1-21-17 10. AGE (In years lost birthday) 53 11. BIRTHPLACE (State or foreign country) New Jersey 12. CITIZEN OF WHAT COUNTRY? USA 13. FATHER'S NAME Henry F. Weissenborn

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager 14B. KIND OF BUSINESS OR INDUSTRY Security Bond 15. MOTHER'S MAIDEN NAME Russell Basford

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 17. SOCIAL SECURITY NO. 18. INFORMANT Charlotte Weissenborn ADDRESS 85 East End Avenue Shrewsbury, N.J.

19. CAUSE OF DEATH 412.4 Arteriosclerotic cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes

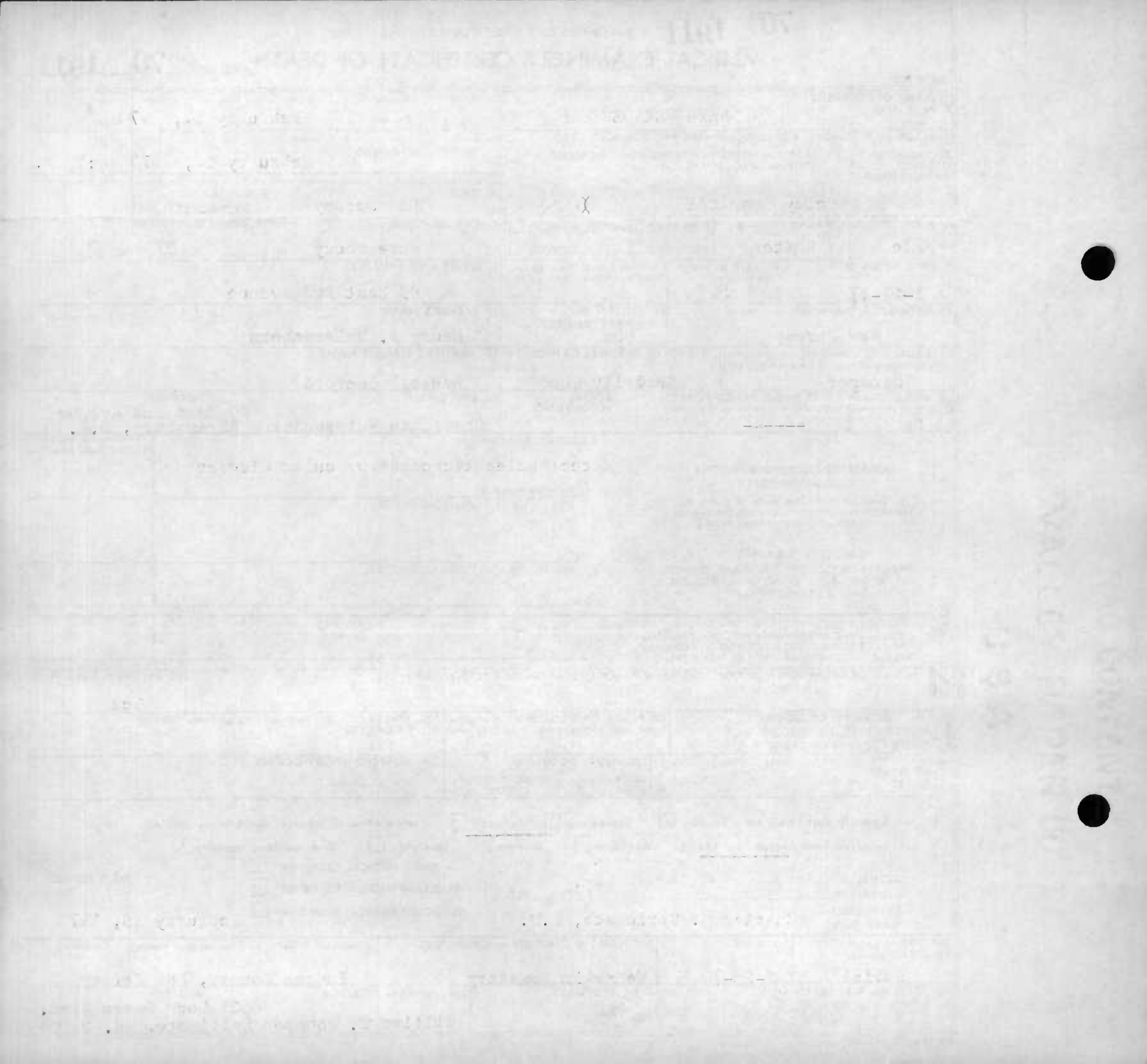
22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED February 15, 1970

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 2-25-70 24C. NAME OF CEMETERY OR CREMATORY Wehawkin Cemetery 24D. LOCATION (City, town, or county) (State) Hudson County, New Jersey

25A. DATE REC'D BY HEALTH DEPT. FEB 17 1970 25B. NAME OF REGISTRAR Robert E. [Signature] 25C. FUNERAL DIRECTOR ADDRESS William E. Johnson Baltimore, Md. 21204



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. [REDACTED] |
|--|--|---|--|--|
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print) WILLIAM BOYER | | 2. DATE AND HOUR OF DEATH
2/14/70 4:15 p.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SOUTH BALTIMORE GENERAL Hos 43 | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md. B. COUNTY AA
C. CITY OR TOWN PASADENA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER Box 386 - GREEN HAVEN | | |
| 5. SEX
Male | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
fork lift operator | | 8. DATE OF BIRTH 9/13/29 9. AGE (In years last birthday) 49
11. BIRTHPLACE (State or foreign country) Severn, Md. 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME
William O Boyer | | 14. MOTHER'S MAIDEN NAME
Mary Albert | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO. 218-01-5779 17. INFORMANT Hospital Records ADDRESS | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
carcinoma lung
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Brain metastases | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 months |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
II | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/2 19 70 to 2/14 19 70
that (I) (we) last saw the deceased alive on 2/14 19 70 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
[Signature] | | 23B. DATE SIGNED
2/14/70 | | |
| 23C. PHYSICIAN'S NAME (Type) DR. C. CHEN | | 23D. ADDRESS
Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE 2/18/70 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 17 1970 | | 25B. NAME OF REGISTRAR Robert E. Fisher, Md. 25C. FUNERAL DIRECTOR Kirkley Funeral Home ADDRESS 421 Crain Hwy. S.E. Glen Burnie, Md. 21061 | | |

[REDACTED]

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
|--|--|---|--|--|--|--|--|---|--|
| FLORENCE HAMMETT | | Known <input type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year Hour | | Month Day Year Hour | | A. STATE B. COUNTY | |
| 46 Lutheran Hospital | | 2 15 70 8:45 A.M. | | Md. Howard 6300 | | | | | |
| 6. SEX Female | | 7. RACE White | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 9. DATE OF BIRTH June 26, 1891 | | 10. AGE (In years last birthday) 78 | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Weldon E. Bowen | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME Carrie King | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT Marie Hammett, RFD # 3, Mt. Airy, Md. | | ADDRESS | | | | | | | |
| 19. 4124 | | CAUSE OF DEATH | | Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| ANTECEDENT CAUSES | | (B) | | DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | (C) | | | | | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | | | | |
| 22D. TIME OF INJURY (APPROX.) | | 22E. INJURY OCCURRED | | 22F. HOW DID INJURY OCCUR? | | | | | |
| 23. | | I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | Feb. 18, 1970 | | Howard Chapel Meth. | | Long Corner, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| FEB 17 1970 | | Russell S. Fisher, M.D. | | Olin L. Molesworth, Damascus, Md. | | | | | |

1913

RECEIVED

7

RECEIVED

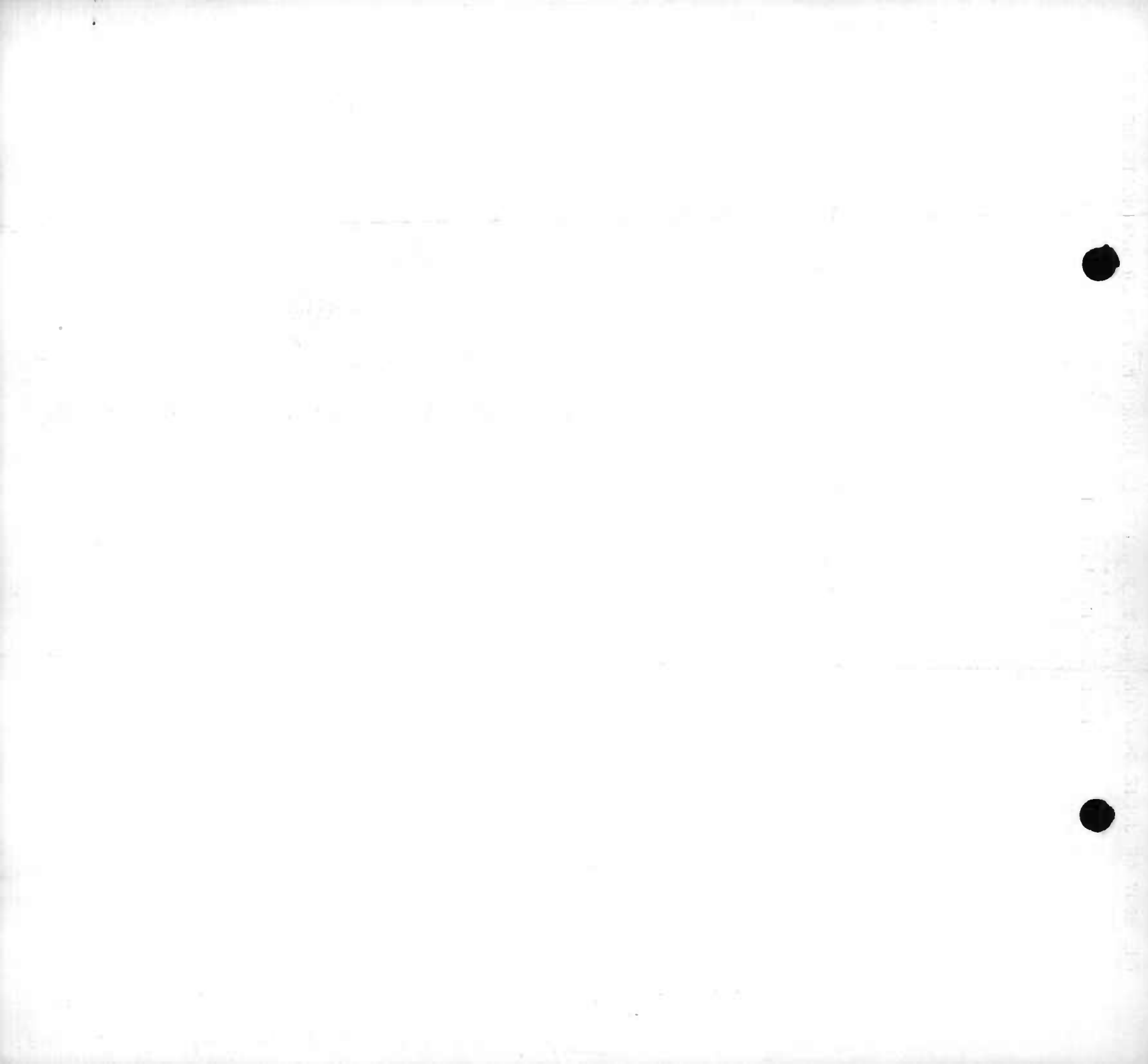
RECEIVED

7

FUNERAL DIRECTOR: IMPORTANT
MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

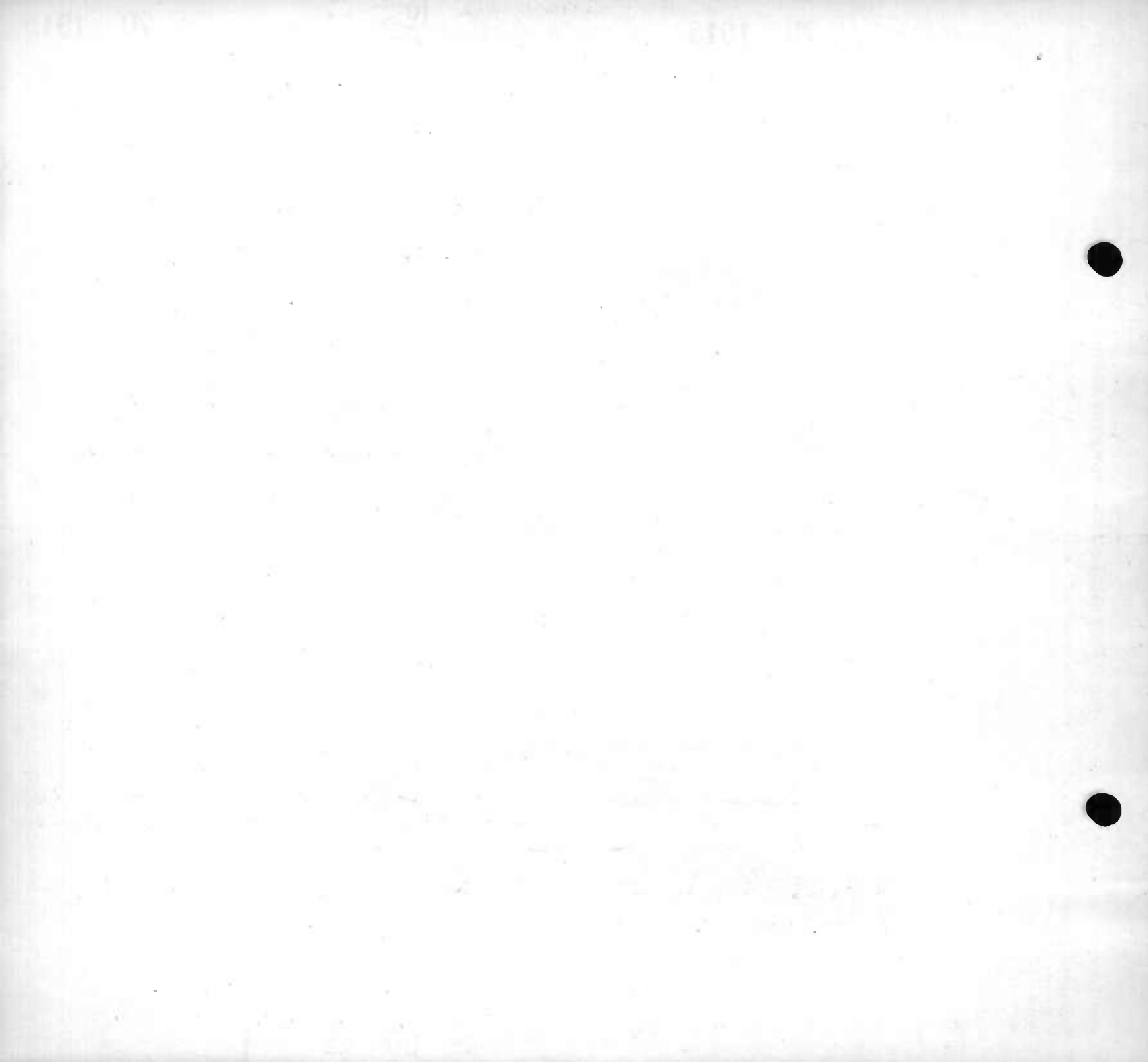
| | | | | | |
|---|------------------|---|-----------------------------------|--|--|
| G-6025-70 1914 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 70 1914 | |
| BIRTH NO. <i>Curroll Co. Md.</i> | | 1. NAME OF DECEASED
(Type or Print) <i>Julie Marie Grayson</i> | | 2. DATE AND HOUR OF DEATH
<i>4/13/70 8:30 P M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Carroll</i> | | 5. CITY OR TOWN <i>Keymar</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>33 Johns Hopkins Hosp.</i> | | E. STREET AND NUMBER
<i>Rt #1</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>6/7/69</i> | 9. AGE (In years last birthday)
<i>8 months</i> | 10. Under 1 Yr. Months: <i>8</i> Days: <i>6</i> If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>U.S. Maryland</i> | |
| 13. FATHER'S NAME
<i>David Grayson</i> | | 14. MOTHER'S MAIDEN NAME
<i>Deanna Will</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>—</i> | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Mr. David Grayson. Keymar, Md.</i> | |
| 18. <i>742.01</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
<i>?? Anoxia</i>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <i>Open Heart Surgery</i>
DUE TO, OR AS A CONSEQUENCE OF:
(C) <i>Congenital Ht. Disease</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>??</i>
<i>7 hrs.</i>
<i>Since Birth</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>2/13/70</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>PDA, Aortic Stenosis</i> | | 20A. AUTOPSY? (Yes or No)
<i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<i>—</i> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
<i>—</i> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
<i>—</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/23</i> 19 <i>70</i> to <i>4/13</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>2/13</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Michael B. Marchildon, MD</i> | | 23B. DATE SIGNED
<i>2/13/70</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>Michael B. Marchildon, MD</i> | |
| 23D. ADDRESS
<i>JHH Dept Surgery</i> | | 23E. DATE SIGNED
<i>2/13/70</i> | | 23F. PHYSICIAN'S NAME (Type)
<i>Michael B. Marchildon, MD</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2-16-1970</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Waverview Mem.</i> | |
| 24D. LOCATION
<i>CARROLL Co. Md.</i> | | 24E. DATE REC'D BY HEALTH DEPT.
<i>FEB 17 1970</i> | | 24F. NAME OF REGISTRAR
<i>Robert E. Venable, Jr.</i> | |
| 24G. FUNERAL DIRECTOR
<i>C. M. Walte</i> | | 24H. ADDRESS
<i>Box 241 Sykesville, Md.</i> | | 24I. DATE REC'D BY HEALTH DEPT.
<i>FEB 17 1970</i> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | 70 1915 | |
|---|-------------------------|---|--|---|--|---|------------------------------|
| BIRTH NO. M-220 70 1915 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) LAURENCE A. McHUGH | | | | 2. DATE AND HOUR OF DEATH
Feb. 15, 1970 4:50 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
44 Union Memorial Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md., 21213
B. COUNTY 831 | | | |
| | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
2819 Pelham Avenue | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 27, 1899 | 9. AGE (In years lost birthday)
70 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Auditor | | 10B. KIND OF BUSINESS OR INDUSTRY
First Nat. Bank | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Michael J. McHugh | | | | 14. MOTHER'S MAIDEN NAME
Ella Neary | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-14-1793 | | 17. INFORMANT ADDRESS
Rose Spartana McHugh, wife, above | | | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Acute Myocardial Infarction
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic C.V.D. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden
years | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
10/25/69 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/8/55 to 2/15/70 , that (I) (we) last saw the deceased alive on 10/25/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
J. Frank Supplee, Jr. | | | | 23B. DATE SIGNED
2/16/70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Frank J. Supplee | | | | 23D. ADDRESS
1010 St. Paul Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/18/70 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, Md. | | 25C. FUNERAL DIRECTOR ADDRESS
Schimunek Funeral Home, Inc. 3331 Brehms Lane | | | |



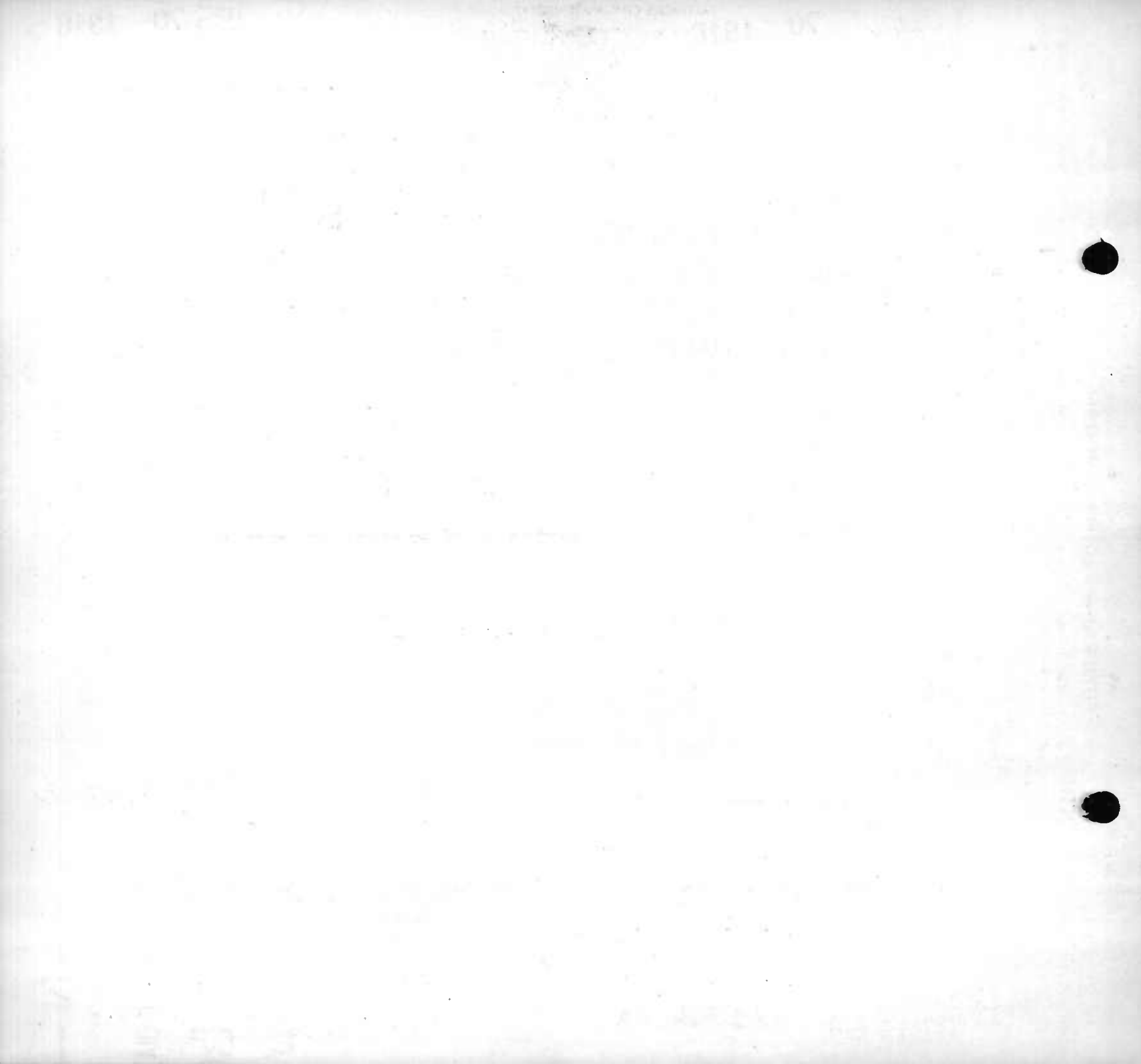
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1916 | | REG. NO. 70 1916 | |
|--|-------------------------|---|--|---|--|---|--|
| BIRTH NO. <u>P-160</u> | | 70 1916 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>KATHERINE MARIE PEPPER</u> | | | | 2. DATE AND HOUR OF DEATH
<u>Feb. 15, 1970</u> <u>6:50 P. M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>90 House in the Pines</u>
<u>Belair Road</u> | | | | A. STATE
<u>Md., 21224</u> | | B. COUNTY | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<u>814 S. Robinson Street</u> | | | |
| 5. SEX
<u>female</u> | 6. RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>11/11/1885</u> | 9. AGE (In years last birthday)
<u>84</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>at home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>John Eydelloth</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>unknown</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Edward L. Hanson, son,</u> | | ADDRESS <u>21236 4244 Darleigh</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>412.44250.9</u>
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Diabetes mellitus Obese</u> | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Acute Stroke</u>
(B) <u>Arteriosclerotic Cerebrovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Hours</u> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/15/1967</u> to <u>2/15/1970</u> , that (I) (we) last saw the deceased alive on <u>2/15/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Albert B. Bradley</u> | | | | 23B. DATE SIGNED
<u>2/17/70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>Dr. Albert B. Bradley</u> | |
| 23D. ADDRESS
<u>4900 B elair Road</u> | | | | 23E. FUNERAL DIRECTOR
<u>Schimunek Funeral Home, Inc.</u> | | ADDRESS
<u>3331 Brehms Lane</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/19/70</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Loudon Park</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 18 1970</u> | | 25B. NAME OF REGISTRAR
<u>John E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Schimunek Funeral Home, Inc.</u> | | ADDRESS
<u>3331 Brehms Lane</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1917 | | 70 1917 | |
|---|---------------------|---|---|--|---|---|------------------------------|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) JAMES T. REARDON | | | | 2. DATE AND HOUR OF DEATH
2-14-70 8:30 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
37 Mercy | | | | A. STATE
Md., 21213 | | B. COUNTY
2633 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
3311 Kentucky Avenue | | | |
| 5. SEX
m | 6. RACE
w | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/30/1906 | | 9. AGE (In years last birthday)
63 | 10. Under 1 Yr. Months Days
11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Wage & Hour Analyst | | | 10B. KIND OF BUSINESS OR INDUSTRY
Labor Dept. | | 11. BIRTHPLACE (State or foreign country)
Penna. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
John Reardon | | | | 14. MOTHER'S MAIDEN NAME
McMannes | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Vera Joyce Reardon, wife, above | | |
| 18. 412.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
1) Congestive heart disease
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
2) Anemia
3) Pneumonia | | | | CAUSE OF DEATH
1) A.S.E.V.I.H.D
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | |
| 19. DATE OF OPERATION
2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-13-1970 to 2-14-1970 that (I) (we) last saw the deceased alive on 2-3-1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
H. Makipour | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type)
HOUSHANG-MAKIPOUR | |
| 23D. ADDRESS
3331 Brehms Lane | | | | 23E. FUNERAL DIRECTOR
Schmunk Funeral Home, Inc. | | 23F. ADDRESS
3331 Brehms Lane | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/18/70 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
James T. Reardon | | 25C. FUNERAL DIRECTOR
Schmunk Funeral Home, Inc. | | 25D. ADDRESS
3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|---|---|---|---|
| <div style="display: flex; justify-content: space-between;"> C-152 70 1918 </div> | | <div style="display: flex; justify-content: space-between;"> BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH </div> | | <div style="display: flex; justify-content: space-between;"> REG. NO. 70 1918 </div> | |
| BIRTH NO. _____
1. NAME OF DECEASED <u>Edward</u>
(Type or Print) <u>ARTHUR E. CAVANAUGH</u> | | | 2. DATE AND HOUR OF DEATH
<u>2-15-70</u> <u>10:20</u> <u>A.</u> M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>90 EDGEWOOD NURSING HOME</u>
<u>6000 BELLONA AVE</u>
<u>BALTIMORE, MD, 21212</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE _____ B. COUNTY _____
<u>3628 CHESTERFIELD AVE</u> <u>MARYLAND</u>
C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>3628 CHESTERFIELD AVE</u> <u>2643</u> | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12-15-00</u> | 9. AGE (In years lost birthday)
<u>69</u> | If Under 1 Yr. Months _____ Days _____
If Under 24 Hrs. Hours _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>STRUCTURAL STEEL WORKER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Bethlehem STEEL INDUSTRY</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME
<u>James Cavanaugh</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Alma Howard</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>114-01-3813</u> | | 17. INFORMANT ADDRESS
<u>Mildred Zang Cavanaugh, wife, above</u> | |
| 18. <u>150 X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>CARCINOMATOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>CARCINOMA OF ESOPHAGUS</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 MOS.</u>
<u>4 MOS.</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-13</u> 19 <u>70</u> to <u>2-15</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>2-14</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Frederick J. Vollmer M.D.</u> | | | | 23B. DATE SIGNED
<u>2-15-70</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>FREDERICK J. VOLLMER M.D.</u> | | 23D. ADDRESS
<u>6100 YORK RD, BALTIMORE, MD 21212</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>2/18/70</u> | 24C. NAME of CEMETERY or CREMATORY
<u>Holy Cross Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 18 1970</u> | | 25B. NAME OF REGISTRAR
<u>J. C. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Schimunek Funeral Home, Inc.</u>
<u>3331 Brehms Lane</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 70 1919 | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. | | 70 1919 | |
|---|------------------|---|---|--|---|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) William V. Pratt | | | | 2. DATE AND HOUR OF DEATH
2-14-70 7:20 A.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
CERTIFICATE AMENDED
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION
BALTIMORE CITY HOSPITALS 2-25-70
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland, Baltimore City 53-00
B. CITY OR TOWN
C. CITY OR TOWN
D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER
2703 W. Woodwell Road 21222 005 | | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-29-10 | 9. AGE (In years last birthday)
59 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | 10B. KIND OF BUSINESS OR INDUSTRY
Steel | | 11. BIRTHPLACE (State or foreign country)
West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Edgar Pratt | | | | 14. MOTHER'S MAIDEN NAME
Eliza Messick | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW 2. | | | 16. SOCIAL SECURITY NO.
320-10-4951-120-10-1591 | | 17. INFORMANT
BCH-Records 4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | |
| 18. 492 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: Pneumothorax of emphysematous bleb
(B) Cardiogenic Shock
DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery Disease
(C) Emphysema | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1/2-4 hrs
2 days
10 years | |
| 19A. DATE OF OPERATION
2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
2 Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If not medical examiner) | | | 21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>2/5</u> 19 <u>70</u> to <u>2/14</u> 19 <u>70</u> and that (2) (we) last saw the deceased alive on <u>2/14</u> 19 <u>70</u> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>W. Lowell</u> MD | | | | 23B. DATE SIGNED
2/14/70 | | 23C. PHYSICIAN'S NAME (Type)
W. Lowell MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
2/18/70 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Herman Cemetery | | 24D. LOCATION (City, town, or county) (State)
Cumberland, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Ullrich Funeral Home Dundalk, Md. | | | | |

V.S. 153

2-25-70

M.H.

70 1920

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1920

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) Ridgeway Leo / Beecher | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
43 South Baltimore General Hospital | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
2 16 70 11:15 P.M. | |
| 6. SEX
male | | 7. RACE
white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
April 9, 1921 | | 10. AGE (In years lost birthday)
48 | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF
U.S. | |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Furniture Finisher | | 14B. KIND OF BUSINESS OR INDUSTRY
Hechts Dept. Store | |
| 15. MOTHER'S MAIDEN NAME
Katherine Rickett | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Yes W W 2 | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Mrs. Vivian May Beecher | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION
3/7/70 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (APPROX.)
Month Day Year Hour
2 16 70 11:15 P.M. | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz M.D.
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.
Deputy Chief Medical Examiner | | 21. AUTOPSY? (Yes or No)
yes | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/20/70 | |
| 24C. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 Robert E. Fisher, M.D. | | 25B. NAME OF REGISTRAR
McCauley F.H. | |
| 25C. FUNERAL DIRECTOR
237 Patapsco Ave. | | 25D. ADDRESS
21225 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1921 | |
|--|---|---|---|--|--|
| <div style="display: flex; justify-content: space-between;"> L-263 70 1921 </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Elmer L. Lockard | | | 2. DATE AND HOUR OF DEATH
February 14, 1970 8 ⁰⁰ P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
5008 Parkton Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER
5008 Parkton Street | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 14, 1892 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY
Fort Holabird | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 13. FATHER'S NAME
Louis Lockard | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT
Mrs. Helen A. Lockard, 5008 Parkton Street | | | ADDRESS | | |
| 18. 428 X I CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

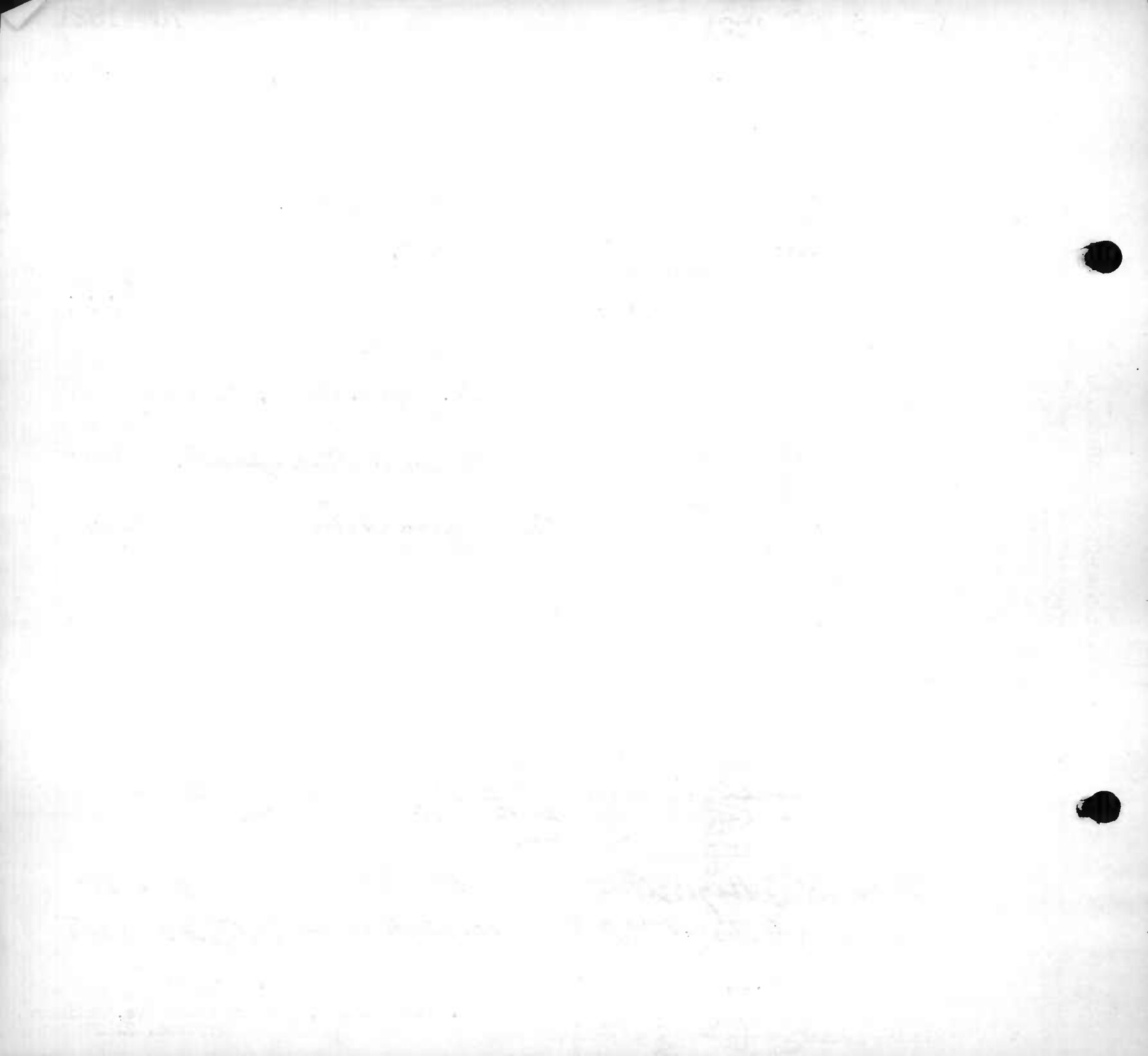
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:

(B) Ch. Myocarditis DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hr.
10 hr. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-19- 1945 to 2-14- 1970 , that (I) (we) last saw the deceased alive on 2-10 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Walter K. Gallager M.D. | | | | 23B. DATE SIGNED
2-16-70 | |
| 23C. PHYSICIAN'S NAME (Type)
Walter K. Gallager M.D. | | | | 23D. ADDRESS
6209 Frederick Ave. Balt., Md. 21228 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Feb. 17, 1970 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
G. Truman Schwab | | 25C. FUNERAL DIRECTOR
G. Truman Schwab, 3512 Frederick Ave. Baltimore, Maryland, 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-400 | | 70 1922 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. [REDACTED] | |
|--|---------------------|--|------------------------------------|--|--|---|--|
| BIRTH NO. | | | | 70 1922 | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>LEWIS ELWOOD</u>
<u>LEWIS BELL</u> | | | | 2. DATE AND HOUR OF DEATH
<u>2-2-70</u> <u>2:45 P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Harbor View Nursing Center</u>
<u>1243 Light St.</u> | | | | A. STATE
<u>Maryland</u> | | B. COUNTY
<u>#212232582</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<u>907 De Soto Road.</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-13-15</u> | 9. AGE (In years last birthday)
<u>55</u> | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SALESMAN</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>PROGRAMMING Co</u> | | 11. BIRTHPLACE (State or foreign country)
<u>SAVAGE MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | 13. FATHER'S NAME
<u>RICHARD ODEN BELL</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>EMMA SANE BARTLEY</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS
<u>LAVERNA HOUSE</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>142.0 I</u>
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Caecum of Perotid i</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>14yr</u> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Medication</u> | | | |
| | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-23</u> 19 <u>70</u> to <u>2-2</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>2-2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Joseph S. Blum</u> | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>2/2/70</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>JOSEPH S. BLUM MD</u> | | | | 23D. ADDRESS
<u>1115 N CALVERT ST.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>2/5/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Ing Hill Cem.</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Laurel Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 18 1970</u> | | 25B. NAME OF REGISTRAR
<u>W. E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Stanford Funeral Home</u> | | ADDRESS
<u>Laurel, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | REG. NO. 70 1923 4 | |
| BIRTH NO. W-160 70 1923 02831 | | 2. DATE AND HOUR OF DEATH
FEBRUARY 13, 1970 10:34 P.M. | |
| 1. NAME OF DECEASED
(Type or Print)
WEBER, BABY BOY ERNEST F. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY HOWARD | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

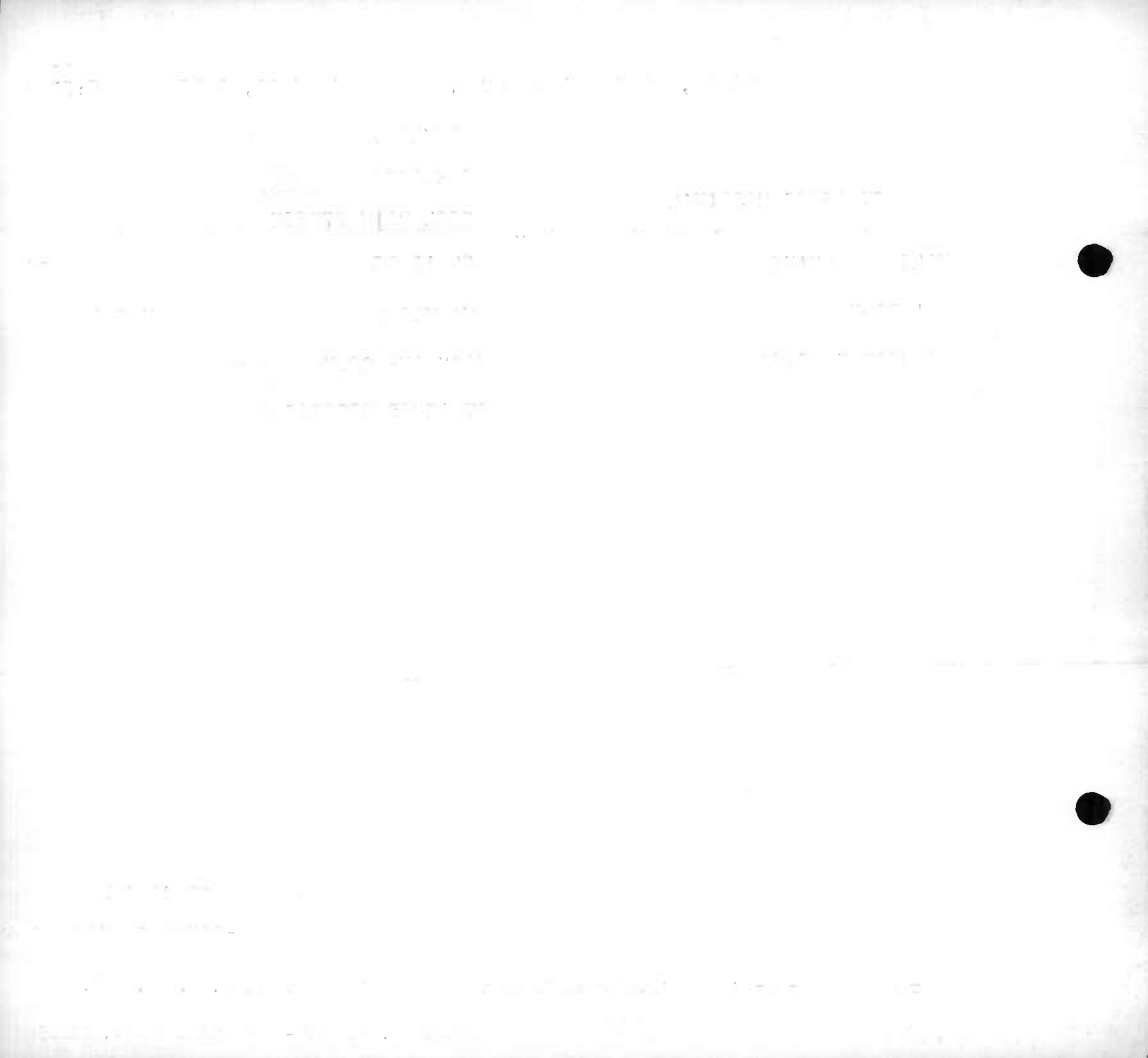
40 ST AGNES HOSPITAL | | C. CITY OR TOWN ELKRIDGE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
5502 MAIN STREET | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
02 13 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
INFANT | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (in years last birthday)
36 |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
ERNEST F WEBER | | 14. MOTHER'S MAIDEN NAME
MARY ANN COOK | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT ADDRESS
ST AGNES RECORDS | |
| 18. CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) ending the UNDERLYING CONDITION last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Multiple congenital abnormality.
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION
0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
NO | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 13, 1970 to Feb 13, 1970 that (I) (we) last saw the deceased alive on Feb 13, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>Chaweng Onkasuwan M.D.</i> | | 23B. DATE SIGNED
02 13 70 | |
| 23C. PHYSICIAN'S NAME (Type)
CHAWENG ONKASUWAN M.D. | | 23D. ADDRESS
81 - Agnes' Hospital CATON & WILKENS AV | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
2-17-70 | 24C. NAME of CEMETERY or CREMATORY
Glen Haven Cemetery | 24D. LOCATION (City, town, or county) (State)
Glen Burnie, A. A. Co. Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | 25B. NAME OF REGISTRAR
<i>James E. Taylor M.D.</i> | 25C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard-4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|--|-------------------------|--|--|---|--|--|---|---|--|--|
| BIRTH NO. <u>R-360</u> | | | | | 70 1924 | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Edna E. Rutter</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>Feb. 14, 1970</u> <u>3:30</u> <u>P.</u> M. | | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>90 Gould Convalescent Home</u> | | | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| E. STREET AND NUMBER
<u>4330 Silver Spring Road - 21128</u> | | | | | | | | | | | |
| 5. SEX
<u>Female</u> | | 6. RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 17, 1885</u> | | 9. AGE (In years lost birthday) <u>84</u> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore City</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>Charles Harvey</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Kate Mundy</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | | 16. SOCIAL SECURITY NO.
<u>213-01-25430</u> | | 17. INFORMANT
<u>Edgar Leroy Rutter Jr.</u> | | | ADDRESS
<u>4330 Silver Spring Rd.</u> | |
| 18. <u>436.9 I</u> CAUSE OF DEATH | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>BRONCHOPNEUMONIA</u> | | | | | | | | | | <u>3 days</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Cerebral accident -</u> | | | | | | | | | | <u>1 wk.</u> | |
| (C) <u>Non-fatal antecedent</u> | | | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/28</u> 19 <u>65</u> to <u>2/14</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>2/12/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
<u>Conrad L. Richter</u> DEGREE | | | | | | | | | 23B. DATE SIGNED
<u>2/16/70</u> | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Conrad L. Richter</u> DEGREE | | | | | | | | | 23D. ADDRESS
<u>3128 Hayford Rd Baltimore</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 24B. DATE
<u>2-17-70</u> | | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Parkwood Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 18 1970</u> | | | 25B. NAME OF REGISTRAR
<u>John C. Miller</u> | | | 25C. FUNERAL DIRECTOR
<u>John C. Miller Inc</u> | | | ADDRESS
<u>6415 Belair Rd. - 21206</u> | | |

Perry Hall, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

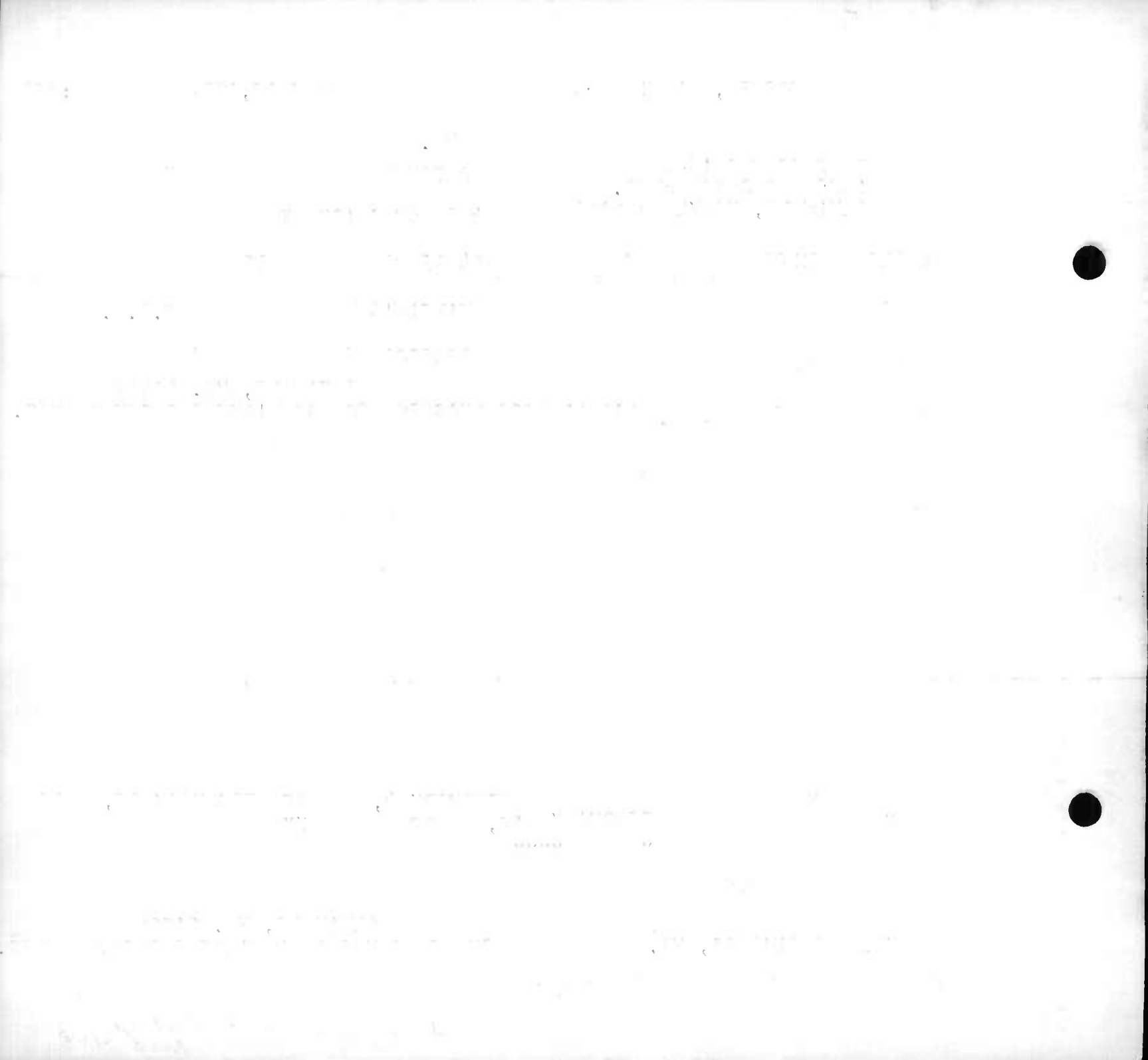
| | | | |
|---|-----------------------------|---|--|
| <div style="display: flex; justify-content: space-between;"> T-360 70 1925 BALTIMORE CITY HEALTH DEPARTMENT </div> | | <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 70 1925 </div> | |
| 1. NAME OF DECEASED
(Type or Print) TETER, HOMER LEWIS | | 2. DATE AND HOUR OF DEATH
FEBRUARY 17, 1970 12:00A | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST. AGNES HOSPITAL
CATON & WILKENS AVES.
BALTIMORE, MARYLAND 21229 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore 53-00 21227
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 3012 FLORIDA AVE. 21227 | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
05 08 25 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
GROUP LEADER | | 10B. KIND OF BUSINESS OR INDUSTRY
RETAIL Mdse Store | 9. AGE (In years last birthday)
44 |
| 11. BIRTHPLACE (State or foreign country)
VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
FLOYD TETER | | 14. MOTHER'S MAIDEN NAME
HILDA (BURNS) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES-WW2 | | 16. SOCIAL SECURITY NO.
227 18 0982 | |
| 17. INFORMANT BALTIMORE, MARYLAND ADDRESS 21229 | | 17. INFORMANT ST. AGNES HOSPITAL-CATON & WILKENS AVES | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
162.1 I
CAUSE OF DEATH
Carcinomatosis.
Antecedent Causes
BRONCHOGENIC CARCINOMA. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR | |
| 22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 13 19 70 to FEBRUARY 17 19 70 that (I) (X) (we) last saw the deceased alive on FEBRUARY 17 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | |
| 23A. SIGNATURE
<i>H. Allen-Mersh</i> | | 23B. DATE SIGNED
02 17 70 | |
| 23C. PHYSICIAN'S NAME (Type)
M. G. ALLEN-MERSH, F.R.C.S. | | 23D. ADDRESS
21229 CATON & WILKENS AVES. BALTIMORE, MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
2/19/70 | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland. |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, R.D.</i> | |
| 25C. FUNERAL DIRECTOR
<i>M. G. Allen-Mersh</i> | | ADDRESS
237 Patapsco Ave. 21225 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1926</u> | |
|--|--|---|--|---|--|
| BIRTH NO. <u>W-256 70 1926</u> | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>WAGNER, MINNIE A.</u> | | 2. DATE AND HOUR OF DEATH
<u>FEBRUARY 15, 1970 3:55P.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>ST AGNES HOSPITAL</u>
<u>WILKENS & CATON AVES.</u>
<u>BALTIMORE, MARYLAND 21229</u> | | A. STATE
<u>MD.</u> | | B. COUNTY
<u>2006</u> | |
| 5. SEX
<u>FEMALE</u> | | 6. RACE
<u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
<u>04 03 97</u> | | 9. AGE (In years last birthday)
<u>72</u> | | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NONE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>VIRGINIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>John INGRAM</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>REBECCA ()</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>212 22 0330</u> | | 17. INFORMANT
<u>BALTIMORE, MD. 21229</u>
<u>STAGNES RECORDS WILKENS & CATON AVES.</u> | | | |
| 18. <u>149 X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>POSSIBLY RESPIRATORY INSUFFICIENCY</u> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>SEVERAL DAYS</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>RETROPHARYNGEAL TUMOR (POSSIBLE METASTASIS)</u> | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>1</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from <u>FEBRUARY 4, 1970</u> to <u>FEBRUARY 15, 1970</u> that (X) (we) last saw the deceased alive on <u>FEBRUARY 15, 1970</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Julio Freijanes</u> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
<u>JULIO FREIJANES, MD.</u> | | 23D. ADDRESS
<u>BALTIMORE, MD. 21229</u>
<u>ST AGNES HOSPITAL WILKENS & CATON AVES.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>2/18/70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>M.T. OLIVER</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>BALTO. MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 18 1970</u> | | | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Barber, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>C. S. MacNally</u>
<u>301 Frederick Rd</u>
<u>Balt 21228</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|---|------------------------------|---|--|---|--|
| 7-655 | | 70 1927 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1927 | |
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH
2/13/70 2:45 PM | | | |
| 1. NAME OF DECEASED
(Type or Print) Catherine V. Froeman | | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 2636 | | | | C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| E. STREET AND NUMBER
6601 Gary Avenue 21224 | | | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-1-1912 | 9. AGE (in years last birthday)
58 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CHARLES Lee, | | | | 14. MOTHER'S MAIDEN NAME
Lottie HADDAWAY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) If yes, give war or dates of service
UNK | | 16. SOCIAL SECURITY NO.
2 18-01-4934 W | | 17. INFORMANT ADDRESS
Records: BCH-4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Acute myocardial infarction 5 days
(B) Atherosclerotic cardiovascular dis 10 yrs
DUE TO, OR AS A CONSEQUENCE OF:
(C) Diabetic mellitus 10 yrs | | | |
| 19. DATE OF OPERATION
2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Feb 6 1970 to Feb 12 1970 that (1) (we) last saw the deceased alive on Feb 12 1970 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
David J. Riley MD | | | | 23B. DATE SIGNED
Feb 13, 1970 | | 23C. PHYSICIAN'S NAME (Type)
David J. Riley | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2/16/70 | | 24C. NAME OF CEMETERY OR CREMATORY
BALTO. CEM | | 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
J. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
J. E. GARNETT SONS | | 25D. ADDRESS
300 MACE | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| F-626 70 1928 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1928 | |
|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) FRAZIER, EUGENE B | | | | 2. DATE AND HOUR OF DEATH
2.15.70 1¹⁵ PM | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE [Where deceased lived, if institution; residence before admission]
A. STATE MD. B. COUNTY BALTO. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
SINAI HOSPITAL | | | | C. CITY OR TOWN
DUNDALK | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX F 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
10/29/22 | | 9. AGE (in years last birthday) 47 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY
WESTERN ELEC. | | 11. BIRTHPLACE (State or foreign country)
W. VA. | |
| 13. FATHER'S NAME
ERNEST BATES | | | | 14. MOTHER'S MAIDEN NAME
LULA ALLEN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNK | | | | 16. SOCIAL SECURITY NO.
379-12-7922 | | 17. INFORMANT
CARL FRAZIER ABOVE | |
| 18. 200.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
LYMPHO SARCOMA
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
~5 yrs. | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (he) (this hospital) attended the deceased from 12.29.70 19 to 2.15.70 19 that (he) (we) last saw the deceased alive on 2.15.70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (He) (We) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
M. Bodner M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
2.15.70 | |
| 23C. PHYSICIAN'S NAME (Type)
M. BODENHEIMER M.D. | | | | 23D. ADDRESS
Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2/18/70 | | 24C. NAME OF CEMETERY or CREMATORY
GARDENS OF FAITH | | 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
Robert J. Kelly, Jr. | | 25C. FUNERAL DIRECTOR
J. J. CONNELLY SONS | | ADDRESS
300 MACE | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|---------|--|------------------|--|---|
| H-553 70 1929 | | CERTIFICATE OF DEATH | | 70 1929 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Harry J. Hammond | | 2/15/70 1:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| | | A. STATE B. COUNTY | | | |
| | | Maryland Baltimore 5300 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| 42 SIN AE. Hosp. Baltimore. | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 223 CLARENDON AV. | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| M. | C | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 3/19/00 | 69 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Clerk | | Food Fair | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Robert E. Hammond | | May Griffin | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 217-05-3922 | | Mrs. Rose Hammond | |
| | | | | ADDRESS | |
| | | | | 223 Clarendon Ave., Pikesville 8, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 7 days | |
| ANTECEDENT CAUSES | | (B) Congestive Heart Failure | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | Diabetes mellitus | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 2/13/70 19 to 2/15/70 19 that (1) (we) last saw the deceased alive on 2/15/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| G. M. V. M. | | 2/15/70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | Feb. 17, 1970 | | Druid Ridge Cem. | |
| 25A. DATE REC'D. BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 18 1970 | | J. E. Baker | | A. J. Zehrig | |
| | | | | ADDRESS | |
| | | | | Cwings Mills, Md. | |

21. 10. 1941

Thats well.

For $\mu \in \mathbb{R}$ and $\sigma \in \mathbb{R}^+$

5/10/20 2 5/10/20

20/10/5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1930 | | 70 1930 | |
|---|------------------|---|---------------------------------|---|---|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | 70 1930 | |
| BIRTH NO. <u>E-430</u> | | | | 1. NAME OF DECEASED
(Type or Print) <u>ARTHUR ELLIS</u> | | 2. DATE AND HOUR OF DEATH
<u>2/16/70</u> <u>18:15</u> A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>UNION MEM. HOSP.</u>
<u>4433RD ST</u>
<u>BALTIMORE, Md. 21218</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>2765</u>
C. CITY OR TOWN <u>BALTIMORE</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>4311 GRANDVIEW AVE</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-17-90</u> | 9. AGE (In years last birthday) <u>79</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND VA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOHN ELLIS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CORA LEWIS</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service
<u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-07-4271A</u> | | 17. INFORMANT <u>Mrs. Mettie M. Ellis</u> | | ADDRESS <u>view Ave.</u>
<u>4311 Grand-</u> | |
| 18. <u>153.0</u> I <u>I</u> CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
19A. DATE OF OPERATION <u>2/13/70</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA CAECUM</u> 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | (A) IMMEDIATE CAUSE <u>PULMONARY EMBOLUS</u>
DUE TO, OR AS A CONSEQUENCE OF:

(B) <u>CA OF CAECUM</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>LIVER METASTASIS</u>

(C) _____ | | | |
| MEDICAL CERTIFICATION
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR? _____ | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JAN. 2</u> 19 <u>70</u> to <u>FEB. 16</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>FEB. 16</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Josef J. Almaraz M.D.</u> 23B. DATE SIGNED <u>2/16/70</u> | | | | 23C. PHYSICIAN'S NAME (Type) <u>JOSEF J. ALMARAZ M.D.</u> 23D. ADDRESS <u>WMH</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/19/70</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>St. Mary's Cem. - Hampden</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 18 1970</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Ann Donovan</u> | | ADDRESS <u>3818 Roland Ave.</u> | |

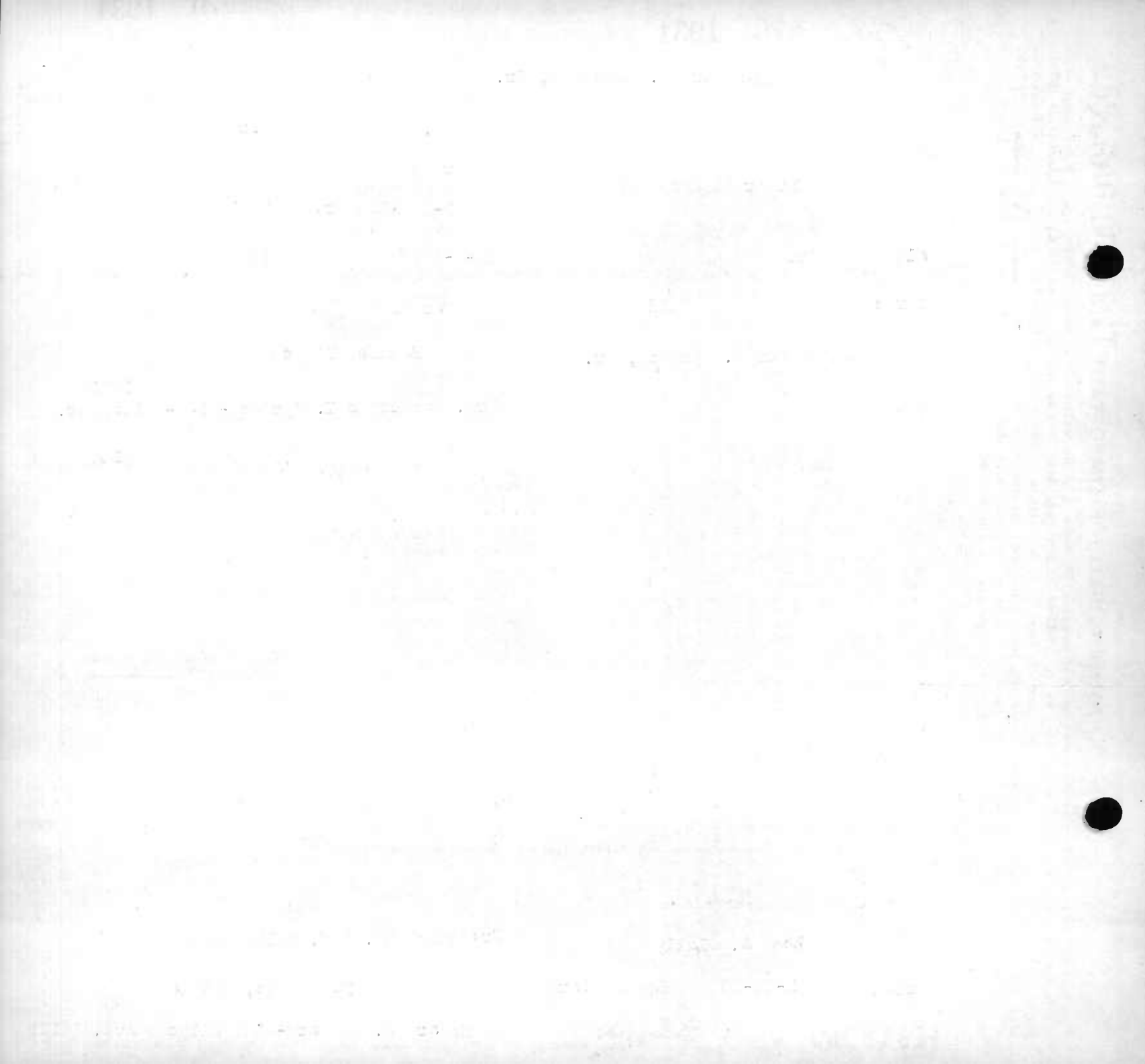


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|-------------------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | 70 1931 | | 70 1931 | |
| BIRTH NO. <u>S-135</u> | | 70 1931 | | REG. NO. <u>X</u> | |
| 1. NAME OF DECEASED
(Type or Print) | | Alexander W. Spedden, Jr. | | 2. DATE AND HOUR OF DEATH
<u>Feb 14 1970</u> <u>1:15</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>44</u> Union Memorial Hospital | | A. STATE
Md. | | B. COUNTY
Baltimore | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
Arbutus | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | E. STREET AND NUMBER
4303-B Alan Drive 21229 | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-6-1898 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Attorney | | 10B. KIND OF BUSINESS OR INDUSTRY
Self | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Alexander W. Spedden, Sr. | | 14. MOTHER'S MAIDEN NAME
Fannie Pippen | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Catherine I. Spedden-4303-B Alan Dr. | |
| 18. <u>410.01</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>Coronary Thrombosis</u>
(B) <u>Hypertension</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 minutes</u>
<u>1 1/2 hr</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1969</u> to <u>Sept 1969</u> , that (I) (we) last saw the deceased alive on <u>Sept 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>Leo A. Lally, M.D.</u> | | 23B. DATE SIGNED
<u>Feb 16 1970</u> | | 23C. PHYSICIAN'S NAME (Type)
Leo A. Lally | |
| 23D. ADDRESS
Frederick Rd. & N. Rolling Road | | 23E. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 23F. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | |
| 23G. FUNERAL DIRECTOR
Howard H. Hubbard-4107 Wilkens Ave. 21229 | | 23H. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23I. DATE
2-18-70 | |
| 23J. NAME OF CEMETERY or CREMATORY
Loudon Park | | 23K. LOCATION
Baltimore, Maryland | | 23L. STATE
(State) | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | X REG. NO. <u>70</u> 1932 |
|---|--|---|--|---|
| G-520 | | 70 1932 | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) Donna Louise Gomez | | 2. DATE AND HOUR OF DEATH
Feb. 14, 1970 3:45 P M. |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Nevada B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
US Public Health Service Hospital
3100 Wyman Parkway | | C. CITY OR TOWN
Reno D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX
F | | 6. RACE
Indian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
3/21/37 9. AGE (In years last birthday)
32 |
| 11. BIRTHPLACE (State or foreign country)
Nevada | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Donald Ridley | | 14. MOTHER'S MAIDEN NAME
Ruby Moore | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT
Records- US PHS Hospital, Balto, Md. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
Carcinoma of the cervix
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Unknown | | | | |
| MEDICAL CERTIFICATION | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (A). | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 11 19 70 to Feb. 14 19 70 that (I) (we) last saw the deceased alive on Feb. 14 19 70 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
Grant P. Simmons, MD | | 23B. DATE SIGNED
2/16/70 | | 23C. PHYSICIAN'S NAME (Type)
Grant P. Simmons, Surg (R) |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-19-1970 | | 24C. NAME OF CEMETERY OR CREMATORY
Stewart Cemetery |
| 24D. LOCATION (City, town, or county) (State)
Stewart, Nevada | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | |
| 25B. NAME OF REGISTRAR
J. E. Taylor, Md. | | 25C. FUNERAL DIRECTOR
Howard H. Hubbar, 4107 Wilkens Ave. 21229 | | |

Wm. Cunningham A. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> I-526 70 1933 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 70 1933 </div> | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) INGRAM JOHN E | | 2. DATE AND HOUR OF DEATH
2/14/70 8 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY | | 5. CITY OR TOWN
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
43 South Baltimore General Hospital | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX m | | 6. RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 8. DATE OF BIRTH
9/22/07 | | 9. AGE (In years last birthday)
62 | | 10. UNDER 1 Yr. Months Days
11. UNDER 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY
Kramme Brothers | | 11. BIRTHPLACE (State or foreign country)
Georgia | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Nathan T Ingram | | 14. MOTHER'S MAIDEN NAME
Mary Byers | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
242 07 0109 | | 17. INFORMANT ADDRESS
Mrs Virginia Vindick | |
| 18. 1621 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CA Lung | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hypoxia | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) Intestinal Obstruction | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
12/11/70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cerebral aneurysm | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/1 19 70 to 2/14 19 70 that (I) (we) last saw the deceased alive on 2/14 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. C. Espinoza | | 23B. DATE SIGNED
2/14/70 | | 23C. PHYSICIAN'S NAME (Type)
J. C. ESPINOZA | |
| 23D. ADDRESS
S. Baltimore General Hospital | | 23E. FUNDING DIRECTOR
McBulley KH V 37 | | 23F. ADDRESS
Fatigue ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/19/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Gulford Mem Cemetery | |
| 24D. LOCATION
High Point | | 24E. STATE
N C | | 24F. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | |
| 24G. NAME OF REGISTRAR
John E. Taylor, M.D. | | 24H. FUNDING DIRECTOR
McBulley KH V 37 | | 24I. ADDRESS
Fatigue ave | |

FUNERAL DIRECTOR: IMPORTANT

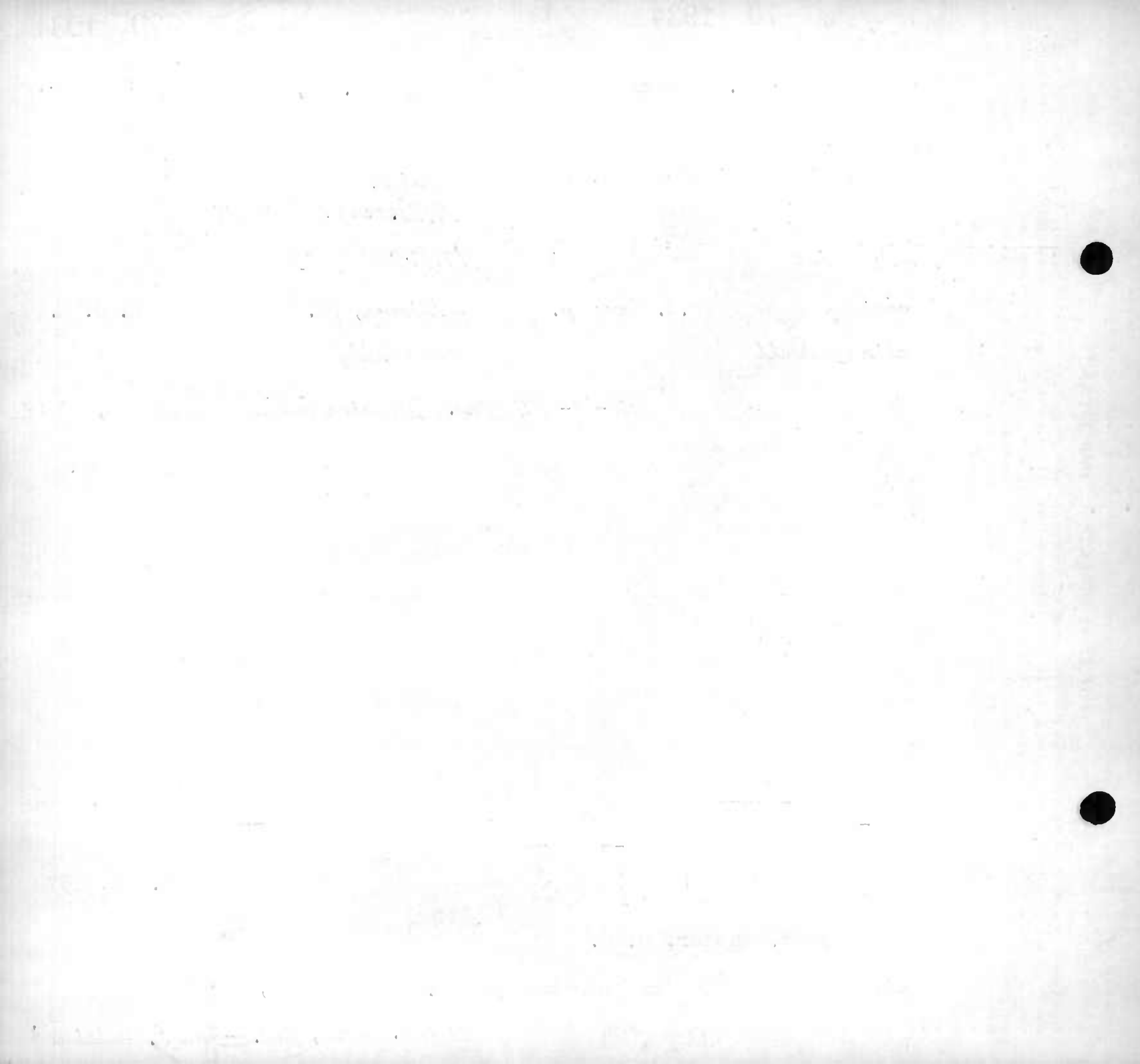
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | 70 1934 | |
|--|--|--|--|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> C-434 70 1934 </div> | | | | <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Marcella J. Caldwell</i> | | | | 2. DATE AND HOUR OF DEATH
<i>Feb. 14, 1970</i> <i>5:55</i> A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>90 House in the Pines - Belvedere</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN <i>Baltimore</i>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>3933 Greenmount Avenue</i> | | | |
| 5. SEX
<i>Female</i> | | 6. RACE
<i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>3/11/1886</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Forelady</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>M. S. Levy Co.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | |
| 13. FATHER'S NAME
<i>Martin Caldwell</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Mary Kelly</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>216-01-2527</i> | | 17. INFORMANT
<i>Mrs. Catherine Brown</i> | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | ADDRESS
<i>3933 Greenmount Avenue Baltimore, 21219</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>8 yrs.</i> | |
| | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic cardiovascular disease</i>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>February 19 63</i> to <i>February 14, 1970</i> , that (I) (we) last saw the deceased alive on <i>February 13, 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Lloyd E. Saylor, M.D.</i> | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>Feb. 16, 1970</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Lloyd E. Saylor, M. D.</i> | | | | 23D. ADDRESS
<i>3902 Greenmount Avenue</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2/17/70</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>New Cathedral Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 18 1970</i> | | 25B. NAME OF REGISTRAR
<i>Lloyd E. Saylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>John A. Moran, Inc.</i> | | ADDRESS
<i>- 3000 E. Baltimore St.</i> | |



FUNERAL DIRECTOR: IMPORTANT

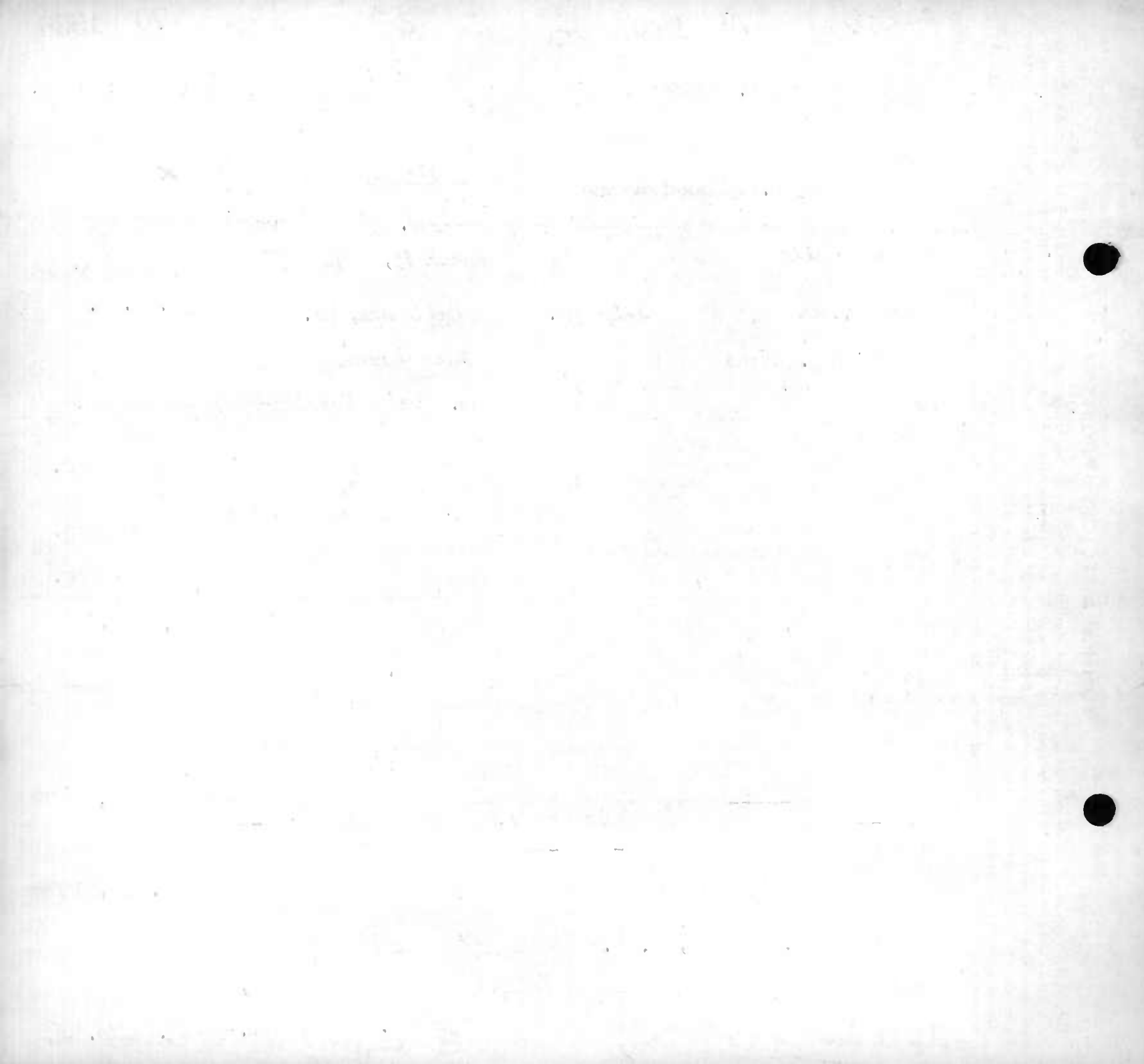
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1935 | |
|---|------------------|---|------------------------------|---|---|
| A-540 70 1935 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) AMELIA, PAQUALE | | 2. DATE AND HOUR OF DEATH
02/14/70 3:30PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
33 JOHNS HOPKINS HOSPITAL | | A. STATE
MARYLAND | | B. COUNTY
2610 | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
118 N. HIGHLAND AVE. | | | |
| 5. SEX
Male
XXXXXX
FEMALE | 6. RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/20/04 | 9. AGE (In years lost birthday)
88 65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Welder | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Italy | |
| 13. FATHER'S NAME
JACK AMELIA S | | 14. MOTHER'S MAIDEN NAME
ROSA ANDREAS | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213 07 6923 | | 17. INFORMANT
Mrs. Mary Amelia 118 N. Highland Ave. | |
| 18. 7-10-71
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
CEREBRAL ANOXIA.
(B) CARDIOGENIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF:
(C) ACUTE MI PLUS RUPTURE OF VENTRICULAR SEPTUM | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 HRS
48 HRS
7 DAYS | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
— | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
— | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
— | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
— | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
— | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/13 1970 to 2/14 1970, that (I) (we) last saw the deceased alive on 2/14 1970 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Michael J. Preece | | 23B. DATE SIGNED
2/14/70 | | 23C. PHYSICIAN'S NAME (Type)
MICHAEL J. PREECE M.D. | |
| 23D. ADDRESS
601 N. BROADWAY, BALTO 5 | | 23E. NAME OF REGISTRAR
John A. Moran, Inc. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/17/70 | | 24C. NAME OF CEMETERY or CREMATORY
Moreland Memorial Park | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. FUNERAL DIRECTOR
John A. Moran, Inc. 3000 E. Baltimore St | | | |
| 25A. DATE RECD BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
John A. Moran, Inc. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
70 1936 CERTIFICATE OF DEATH | | | | REG. NO. 70 1936 | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. 6-650 | | 1. NAME OF DECEASED
(Type or Print) <u>Margaret M. Byrne</u> | | 2. DATE AND HOUR OF DEATH
<u>February 14, 1970</u> <u>10:30</u> A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>102</u> | | C. CITY OR TOWN <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>00</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>265 S. Ellwood Avenue</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
<u>Female</u> | 6. RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 15, 1892</u> | 9. AGE (In years last birthday)
<u>77</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Dress Maker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Self-Emp.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME
<u>Patrick J. Byrne</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Gannon</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Yes</u> | | 17. INFORMANT
<u>Mrs. Evelyn Vonsteg-7809 Wendover Ave</u> | |
| 18. <u>412.2</u> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Hypertension</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Arteriosclerotic cardiovascular disease</u> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>Hypertension</u>
(B) <u>disease</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>Osteoporosis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 yrs.</u>
<u>10 yrs.</u>
<u>15 yrs.</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>62</u> to <u>February 14</u> , 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>February 7</u> , 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Lloyd E. Saylor, M.D.</u> | | | | 23B. DATE SIGNED
<u>Feb. 16, 1970</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Lloyd E. Saylor, M. D.</u> | | | | 23D. ADDRESS
<u>3902 Greenmount Avenue</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2/18/70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Gardens of Faith Cemetery</u> | |
| 24D. LOCATION
<u>Baltimore, Maryland</u> | | 24E. FUNERAL DIRECTOR
<u>John A. Moran, Inc. - 3000 E. Balto. St.</u> | | 24F. ADDRESS
<u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 18 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Barber, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>John A. Moran, Inc. - 3000 E. Balto. St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1937 | |
|--|--|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> H-612 70 1937 </div> | | | | | |
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print) Edward J. Hrubes | | | 2. DATE AND HOUR OF DEATH
February 14, 1970 M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Church Home & Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 602 | | |
| 5. SEX Male 6. RACE White | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec. 27, 1919 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. Gas & Elec. | | 9. AGE (In years last birthday)
50 Yrs. |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
James Hrubes | | | 14. MOTHER'S MAIDEN NAME
Sophia Kohl | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes WW 17 | | | 16. SOCIAL SECURITY NO.
212-05-7196 | | 17. INFORMANT
Mrs. Virginia Hrubes |
| 18. 410.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
myocardial infarction
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Coronary insuff
(B) DUE TO, OR AS A CONSEQUENCE OF:
hypertensive CVD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr?
3-4 yrs?
2-3 yrs? |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1958 to Feb 11 19 70 , that (I) (we) last saw the deceased alive on Feb 11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
[Signature] M.D. | | | | 23B. DATE SIGNED
2/16/70 | |
| 23C. PHYSICIAN'S NAME (Type)
BURTON V. LOCK | | | | 23D. ADDRESS
2936 E Balto St | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/18/70 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | | |
| 25B. NAME OF REGISTRAR
John A. Moran, Inc. | | 25C. FUNERAL DIRECTOR ADDRESS
3000 E. Baltimore St | | | |

Handwritten notes, possibly a list or index, including the words "Government" and "information".

Handwritten notes at the bottom of the page, including the name "Barton V. Beck" and the date "2/10/20".

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|------------------|--|---|
| <p>BIRTH NO. 11-425 70 1938</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 70 1938</p> | | | |
| 1. NAME OF DECEASED
(Type or Print)
<u>Mrs. Elizabeth Millikan</u> | | 2. DATE AND HOUR OF DEATH
<u>2/15/70</u> 1 <u>14</u>⁰⁰ | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>CHURCH HOME HOSPITAL</u>
<u>33</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>2102</u>
C. CITY OR TOWN <u>BALTIMORE</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>1148 CLEVELAND STREET.</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-16-98</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOMEMAKER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>71</u> |
| 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>CHARLES HERGET</u> | | 14. MOTHER'S MAIDEN NAME
<u>CHRISTINE SAUER</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>212 48 4328</u> | |
| 17. INFORMANT
<u>AMELIA BERKOWITZ</u> | | ADDRESS
<u>3812 SEQUOIA AV</u> | |
| 18. <u>15401</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>II</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>CARDIO-RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF:
(B) <u>CA of RECTOSIGMOID & MULTIPLE</u>
DUE TO, OR AS A CONSEQUENCE OF:
(C) <u>MYELOWID</u>

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>24 HRS.</u>
<u>6 MON.</u> | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nationally medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/6/70</u> 19 <u>70</u> to <u>2/15</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/15/70</u> 19 <u>70</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>Cesar A. Lopez MD</u> | | 23B. DATE SIGNED
<u>Feb. 16, 1970</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>CEZAR A. LOPEZ MD</u> | | 23D. ADDRESS
<u>CHURCH HOME AND HOSP.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>burial</u> | | 24B. DATE
<u>2/18/70</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY
<u>Western Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 18 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor MD</u> | |
| 25C. FUNERAL DIRECTOR
<u>Mitchell-Wiedefeld Home</u> | | ADDRESS
<u>6500 York Rd. Balto.</u> | |

1000 1000 1000
1000 1000 1000
1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> 7-200 70 1939 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | REG. NO. 70 1939 | |
| BIRTH NO. 7-200 | | | |
| 1. NAME OF DECEASED
(Type or Print) THOMAS LAWRENCE ROCHE JR. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE MD B. COUNTY BALTO. | |
| FULL NAME OF HOSPITAL OR INSTITUTION
NORTH CHARLES GENERAL HOSPITAL
NORTH CHARLES ST. + S.E. BALTIMO. | | C. CITY OR TOWN CITY BALTIMORE D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX MALE 6. RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY
Balto. Police Dept. | |
| 13. FATHER'S NAME
JAMES ROCHE | | 14. MOTHER'S MAIDEN NAME
HOPKINSON Mary Horgan | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
218-36-1002 | |
| 17. INFORMANT
Mrs. Betty Doran (Daughter) | | ADDRESS
1203 2702 GREENMOUNT AVE. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
MYOCARDIAL INFARCTION.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
PULMONARY EMPHYSEMA
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | |
| 19. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
THROMBOSIS Rt. VEG. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
NORTH CHARLES HOSPITAL | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/15 1970 to 2/12 1970 , that (I) (we) last saw the deceased alive on 2/12 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> | |
| 23A. SIGNATURE
Victor Salama MD | | 23B. DATE SIGNED
2/12/70 | |
| 23C. PHYSICIAN'S NAME (Type)
VICTOR SALAMA | | 23D. ADDRESS
North Charles Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/17/70 | |
| 24C. NAME of CEMETERY or CREMATORY
Dulaney Valley Mem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Co. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor M.D. | |
| 25C. FUNERAL DIRECTOR
Mitchell J. ... | | ADDRESS
1203 2702 Greenmount Ave. | |

1910. 11/10/10.

1910. 11/10/10.

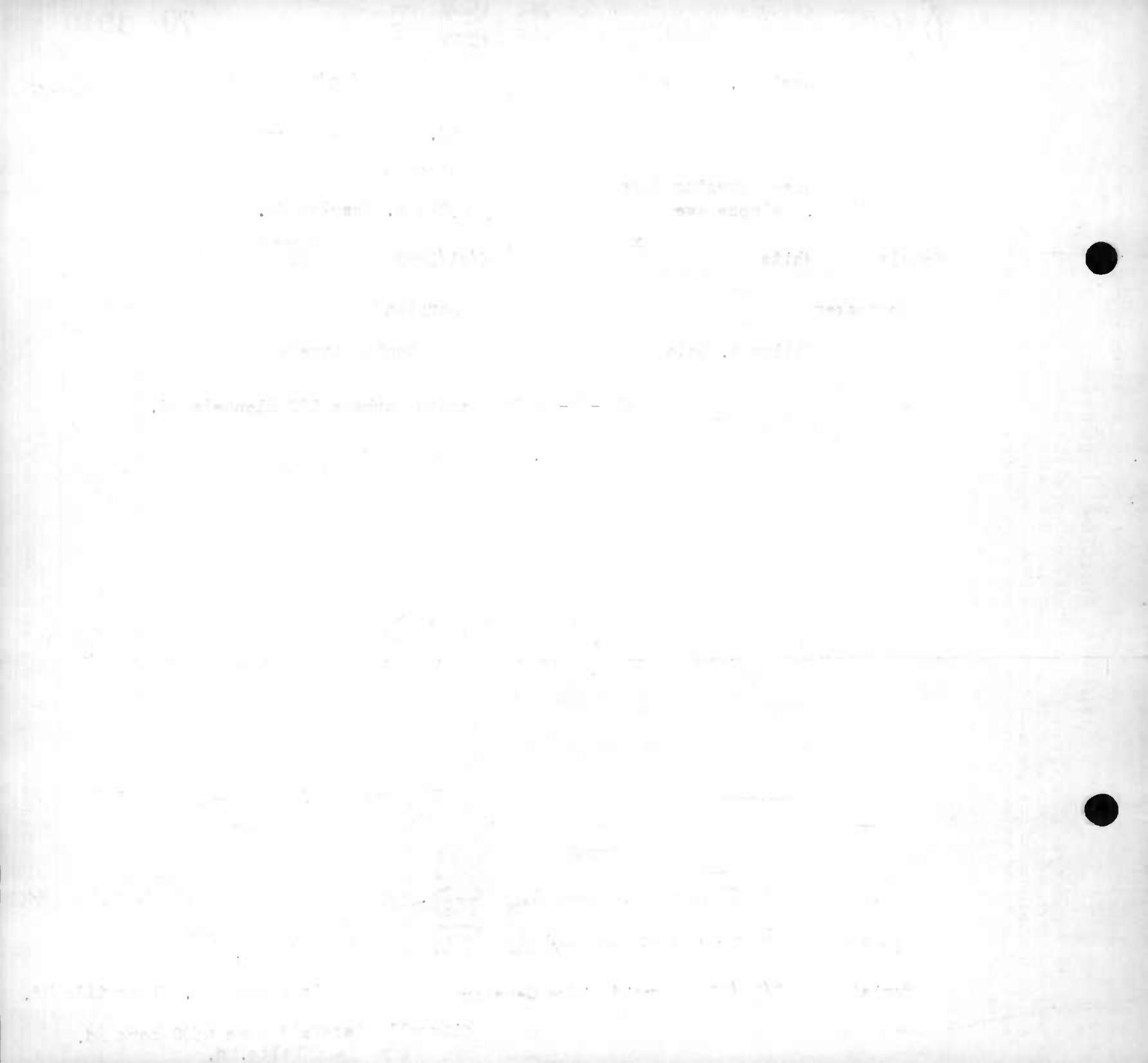
1910. 11/10/10. (1910. 11/10/10.)

1910. 11/10/10. 1910. 11/10/10. 1910. 11/10/10.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 70 1940 | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. D-612 | | 70 1940 | | | |
| 1. NAME OF DECEASED
(Type or Print) Annie G. Burbage | | | 2. DATE AND HOUR OF DEATH
2/15/1970 | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Long Green Nursing Home
115 E. Melrose Ave | | | A. STATE Md. B. COUNTY Baltimore | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
3215 N. Charles St. | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/31/1887 | 9. AGE (In years lost birthday)
82 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
William R. Gale | | |
| 14. MOTHER'S MAIDEN NAME
Annie Stavelly | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO.
083-05-7530B | | | 17. INFORMANT ADDRESS
Landon Burbage 202 Blenheim Rd. | | |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Cirrhosis of liver | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Cirrhosis of liver | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
ASCVD | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yr. | | |
| 19A. DATE OF OPERATION
9 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from Sept 13 19 62 to Feb 15 19 70 .
that (I) (was) last saw the deceased alive on Jan 28 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE
Norman R. Freeman | | | | 23B. DATE SIGNED
Feb 16, 1970 | |
| 23C. PHYSICIAN'S NAME (Type)
NORMAN R. FREEMAN JR | | | | 23D. ADDRESS
11 W. 24th St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/17/70 | | 24C. NAME OF CEMETERY or CREMATORY
Druid Ridge Cemetery | |
| 24D. LOCATION
Reistertown Rd, Pikesville Md. | | (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Mitchell Wiedefeld Home 6500 York Rd. Balto. Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

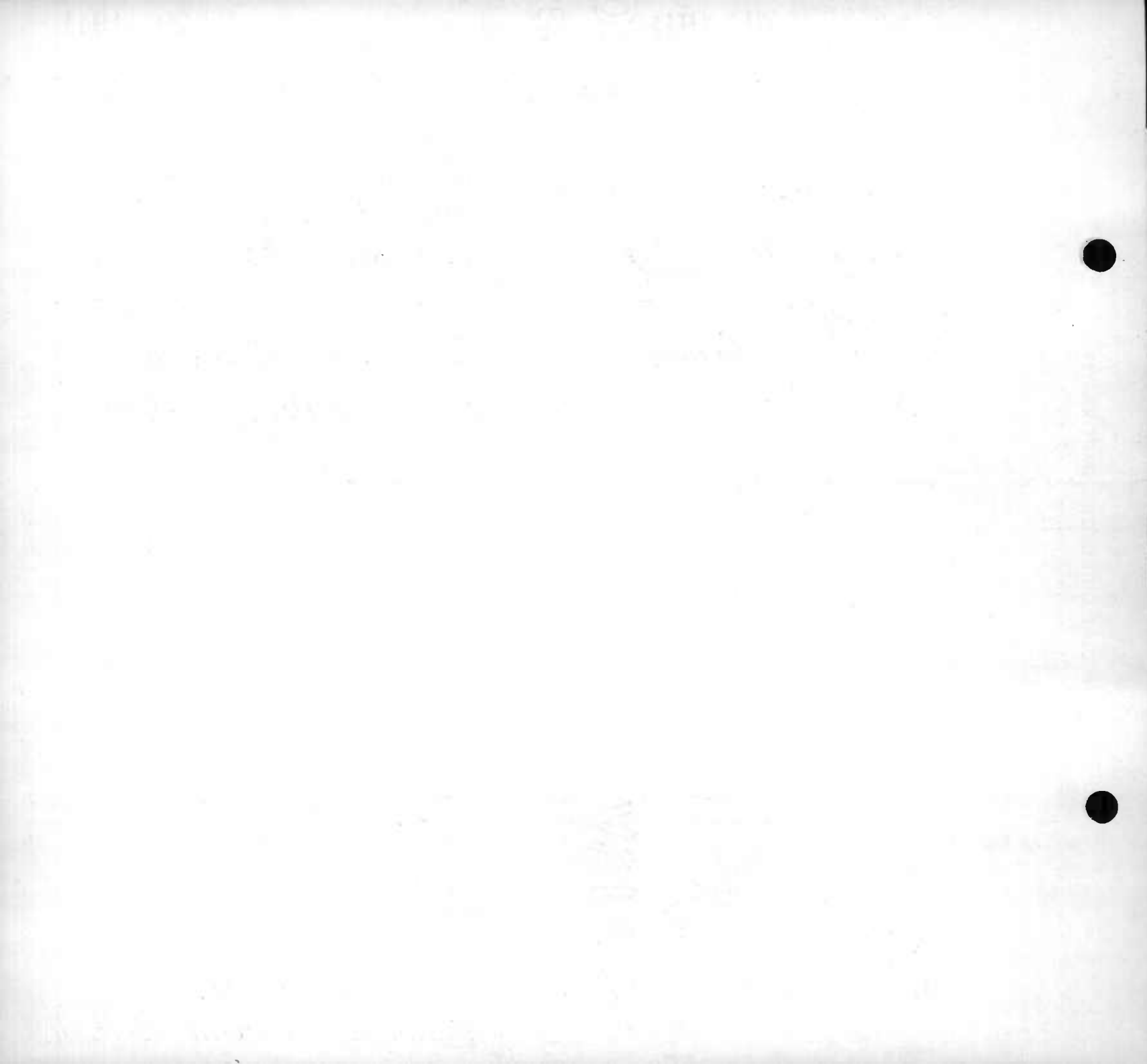
| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 70 1941 |
|--|---|--|--|---|
| BIRTH NO. B-400 | | 70 1941 | | |
| 1. NAME OF DECEASED
(Type or Print) FLORENCE E. BAILEY | | 2. DATE AND HOUR OF DEATH
Feb 13 1970 2 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
44 UNION MEMORIAL Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Baltimore
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3431 Falls Rd | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN 31 1880 | 9. AGE (In years lost birthday) 90 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Md |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Louis C Deems | | |
| 14. MOTHER'S MAIDEN NAME Elizabeth Murphy | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Virginia M Harp ADDRESS same | | |
| 18. 4121-I | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) IMMEDIATE CAUSE arteriosclerotic C.V. Dis
DUE TO, OR AS A CONSEQUENCE OF:

(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____ | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 1960 to Feb. 13 1970 , that (I) we last saw the deceased alive on June 19 69 and that in (my) per opinion death occurred on the date and hour and from the causes stated above. (I) We (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Edward L. Glassman MD | | 23B. DATE SIGNED 2/14/70 | | 23C. PHYSICIAN'S NAME (Type) EDWARD L. GLASSMAN MD |
| 23D. ADDRESS 4037 Falls Rd | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 2-17-70 | | 24C. NAME OF CEMETERY or CREMATORY Cathedral Cem | | 24D. LOCATION (City, town, or county) (State) Baltimore Md |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 18 1970 | | 25B. NAME OF REGISTRAR Robert E. Fisher, Jr. | | 25C. FUNERAL DIRECTOR Burgess Funeral Home ADDRESS Baltimore Md |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>70 1942</u> |
|---|----------------------|---|--|--|
| BIRTH NO. <u>H-530</u> <u>70</u> <u>1942</u> | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>William HUNT (WILLIAM HUNT)</u> | | 2. DATE AND HOUR OF DEATH
<u>2/14/70</u> <u>11:50 a.m.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>13 SOUTH BALTIMORE GENERAL HOS</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u>
B. COUNTY <u>1101</u>
C. CITY OR TOWN (BALTO) <u>Baltimore</u>
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>1301 St. Paul St.</u> <u>1301 St. Paul St.</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 27, 1887</u>
<u>6-27-87</u> | 9. AGE (In years last birthday) <u>82</u>
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired - Engineer</u>
<u>UNKNOWN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Boiler Mfg. Ind.</u>
<u>UNKNOWN</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Middletown, Delaware</u>
<u>Delaware</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u>
<u>U.S.A</u> | | 13. FATHER'S NAME
<u>(Decd) WILLIAM M. HUNT</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>(Decd) ELLEN STRUDWICK</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>no</u> <u>None</u> | | |
| 16. SOCIAL SECURITY NO.
<u>215-10-1135</u> | | 17. INFORMANT: <u>Sister</u>
<u>Mrs. Walter Bradley</u> , <u>Salisbury, Md.</u>
<u>Chart</u> | | |
| 18. <u>412.41</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<u>CHF with atrial fibrillation</u>
<u>ASCVD</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/12</u> 19 <u>70</u> to <u>2/14</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/14</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
<u>[Signature]</u> | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>CECILIA CHEN</u> | | 23D. ADDRESS
<u>3001 S. Hanover St.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>Feb. 17, 70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>LORRAINE PARK CEMETERY</u> |
| 24D. LOCATION (City, town, or county) (State)
<u>WOODLAWN, BALTO. CO., MD.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 18 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Talley, Md.</u> | | 25C. FUNERAL DIRECTOR
<u>STEWART & MOWEN CO.</u> |
| 25D. ADDRESS
<u>108 W. North Av., Cityl</u> | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| T-655 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1943 | |
|---|-----------|--|------------------|---|---|--|--|
| BIRTH NO. | | | | REG. NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| GENETTE TERAMANI | | | | Feb. 14, 1970 | | 11.55 p. m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 90 HOUSE IN THE PINES BELLAIRE | | | | Maryland | | | |
| | | | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER | | | |
| | | | | 5514 Knell Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| female | caucasian | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | June 19, 1892. | 77 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | | | Italy | | Italy | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Marcello DiGiovanni | | | | Grace Mazoc | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | | | Mr. Alexander Teramani (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | C-V-A | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-10-1965 to 2-14-1970, that (I) (we) last saw the deceased alive on 2-14-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Dr. Sebastian Russo | | | | 2-16-70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| | | | | 5017 Harford Road, Balto, Md. - 14 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2/18/70. | | Gardens of Faith Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 18 1970 | | Robert E. Taylor | | Leonard J. Ruck, Inc. - Balto, Md. - 14 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1944 | |
|--|---------------------|---|---|--|--|
| H-300 70 1944 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>AGNES HEWETT (Hewitt)</i> | | 2. DATE AND HOUR OF DEATH
<i>FEB. 16, 1970 5:50 A.M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>2733</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Park Hill Convalescent Home</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<i>Baltimore</i> | |
| D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
<i>2905 Echodale Ave.</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Oct. 3, 1874</i> | 9. AGE (In years lost birthday)
<i>95</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>America</i> | | 13. FATHER'S NAME
<i>Nicholas Hoffman</i> | | 14. MOTHER'S MAIDEN NAME
<i>Agnes Schultze</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>218-52-0227</i> | | 17. INFORMANT
<i>Mrs Cyril Gunther 2620 Evergreen Ave</i> | |
| 18. <i>422.01</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>CHF</i> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>CHF</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2d</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<i>Quarantine</i> | | | | | |
| 19A. DATE OF OPERATION
<i>10 7 1970</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5 am</i> <i>1966</i> to <i>16 7 1970</i> , that (I) (we) last saw the deceased alive on <i>16 7 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>S. Hulla</i> | | 23B. DATE SIGNED
<i>16 7 1970</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>S. Hulla</i> | |
| 23D. ADDRESS
<i>2214 E. Taylor St.</i> | | 23E. DATE SIGNED
<i>16 7 1970</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2/18/70</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Baltimore</i> | |
| 24D. LOCATION
<i>Baltimore, Maryland</i> | | 24E. DATE SIGNED
<i>16 7 1970</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 18 1970</i> | | 25B. NAME OF REGISTRAR
<i>Leonard J. Ruck Inc.</i> | | 25C. FUNERAL DIRECTOR
<i>Leonard J. Ruck Inc. Baltimore, Maryland</i> | |

1. The first part of the report is a general description of the project and its objectives.

2. The second part of the report is a detailed description of the methodology used in the study.

3. The third part of the report is a discussion of the results of the study.

4. The fourth part of the report is a conclusion and recommendations.

5. The fifth part of the report is a list of references.

6. The sixth part of the report is a list of appendices.

7. The seventh part of the report is a list of figures and tables.

8. The eighth part of the report is a list of footnotes.

9. The ninth part of the report is a list of abbreviations.

10. The tenth part of the report is a list of symbols.

11. The eleventh part of the report is a list of units.

12. The twelfth part of the report is a list of acronyms.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1945

BIRTH NO.

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
FLORENCE HARDY | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
February 14, 1970 12:35 P.M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
2001 E. Preston Street | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
February 14, 1970 12:35 P.M. | |
| 6. SEX
Female | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
March 1, 1893 | | 10. AGE (In years lost birthday)
76 | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Hardy | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Home Maker | |
| 15. MOTHER'S MAIDEN NAME
Mary Norris | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Mr Howard Hardy 106 Chatham Place Belair Md | |
| 19. CAUSE OF DEATH
Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 20A. DATE OF OPERATION
0 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
No | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 22D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/17/70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Cokesburg | | 24D. LOCATION (City, town, or county) (State)
Abington, Harford Co Md/ | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
Leonard J Ruck Inc. Baltimore Maryland | | ADDRESS | |

ACADEMIC & JIND

RAJ SOVIET

VALLEY PACIFIC CO

Serial

21170

Robertson

Abington, Arthur

Edward J. McKinnon, Jr.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

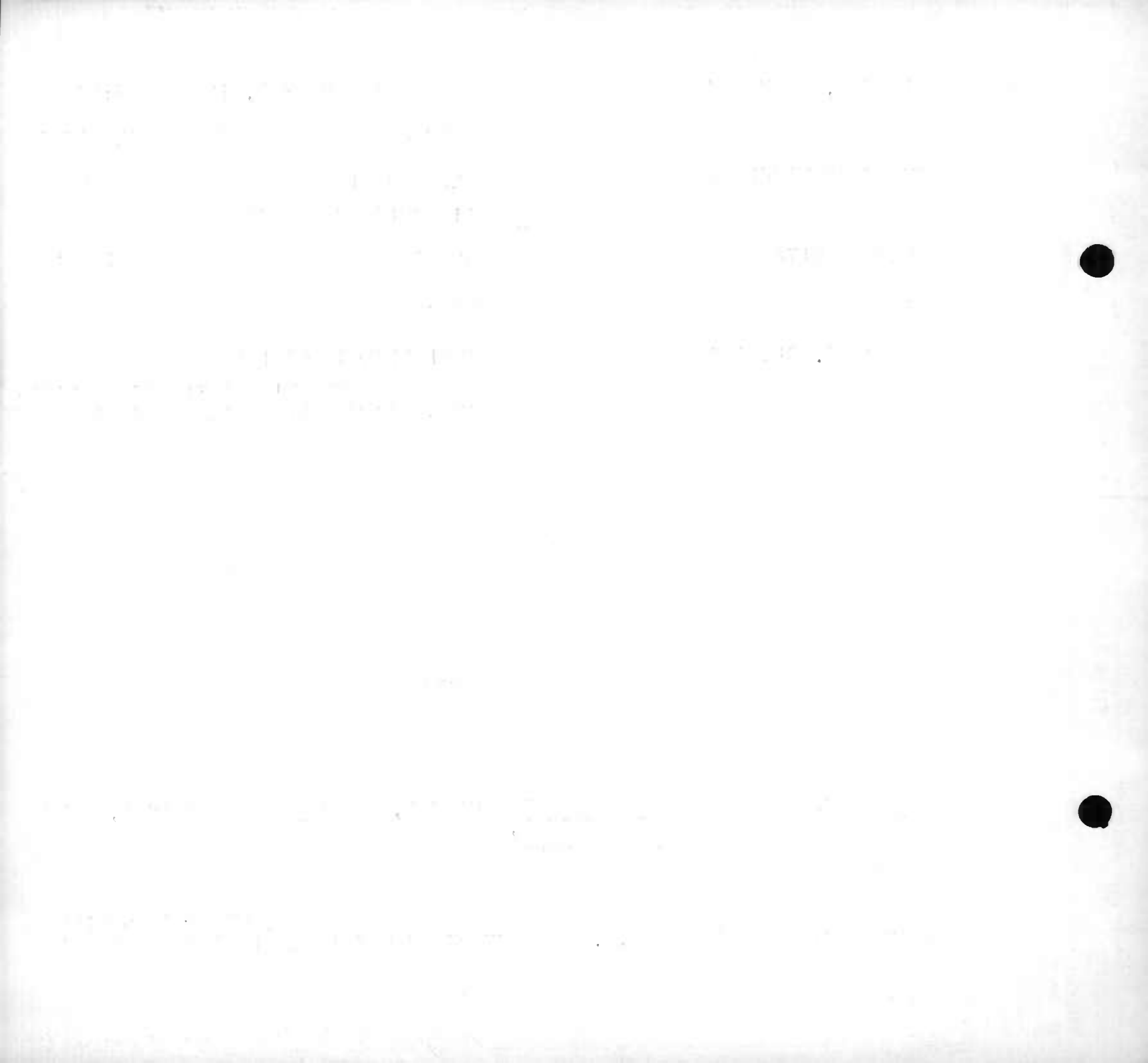
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1946</u> | |
|--|-----------------------------|---|---|---|---|
| BIRTH NO. <u>K-152</u> | | 70 1946 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>JOHN GUY KAVANAGH</u> | | | 2. DATE AND HOUR OF DEATH
<u>2 / 16 / 1970 3.20 PM.</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>MD. GEN. HOSPITAL</u>
<u>48</u> | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<u>3135 Weava Ave Md 21214.</u> | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/31/1903</u> | 9. AGE (In years last birthday)
<u>66.</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Salesman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Retd.</u> | 11. BIRTHPLACE (State or foreign country)
<u>md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> |
| 13. FATHER'S NAME
<u>James D. Kavanagh</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Honora Devine</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>216-10-2308</u> | 17. INFORMANT
<u>Mrs Catherine Kavanagh</u> | | ADDRESS
<u>Same</u> |
| 18. <u>492X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)
<u>BRONCHOPNEUMONIA</u>
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>PULMONARY EMPHYSEMA</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<u>Chronic Bronchitis</u>
(C) <u>Arteriosclerosis (CVA)</u>
<u>+ Cerebro-</u>
<u>Arterio Sclerotic Cardio Vascular Disease.</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 Days - 6 Wks</u>
<u>4 yrs</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Arterio Sclerotic Cardio Vascular Disease.</u> | | | | | |
| 19A. DATE OF OPERATION
<u>2/15/70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes.</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/15/70</u> to <u>2/16/1970</u> that (I) (we) last saw the deceased alive on <u>2/16/1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Mohamed S Al- Ibrahim</u> | | | 23B. DATE SIGNED
<u>2/16/1970</u> | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)
<u>M. S. AL-IBRAHIM</u> | | | 23D. ADDRESS
<u>Md. General Hospital.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>2/20/70</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>New Cathedral</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 18 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert G. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Leonard J. Ruck Inc. Baltimore, Maryland</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. 70 1947 4 | |
|--|------------------|--|------------------------------|---|---|
| BIRTH NO. 3-416 70 1947 70-02742 | | 2. DATE AND HOUR OF DEATH
FEBRUARY 4, 1970 5:00A M. | | | |
| 1. NAME OF DECEASED
(Type or Print)
GILBERT, BABY BOY | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST AGNES HOSPITAL
40 | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE
MARYLAND
C. CITY OR TOWN
GLEN BURNIE
E. STREET AND NUMBER
315 STIEMLY AVENUE | | B. COUNTY
ANNE ARUNDEL 21061
D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
02 03 70 | 9. AGE (In years last birthday)
18 49 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NEWBORN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
ROBERT G. GILBERT | | | |
| 14. MOTHER'S MAIDEN NAME
(HAIRFIELD) PATRICIA | | 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
RECORD IS BALTIMORE MD 21229
ST AGNES HOSPITAL WILKENS & CATON AVE | | | |
| 18. 776.91 CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 3, 1970 to FEBRUARY 4, 1970 that (I) (we) lost saw the deceased alive on FEBRUARY 4, 1970 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.
23A. SIGNATURE
Krita Apibumyopas, M.D.
23B. DATE SIGNED
Feb. 6, 1970
23C. PHYSICIAN'S NAME (Type)
KRITA APIBUMYOPAS M.D.
23D. ADDRESS
BALTIMORE MD 21229
ST AGNES HOSPITAL WILKENS & CATON AVE
24A. BURIAL CREMATION, REMOVAL (Specify)
Burial
24B. DATE
2/18/70
24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970
25B. NAME OF REGISTRAR
Robert E. Taylor, M.D.
25C. FUNERAL DIRECTOR
Withey, F. H.
25D. ADDRESS
4101 Edmondson Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1948 9 | |
|---|--|---|--|---|--|
| BIRTH NO. K-52370 1948
1. NAME OF DECEASED
(Type or Print) KNIGHT, BABY GIRL | | 2. DATE AND HOUR OF DEATH
JANUARY 9, 1970 10:20 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 2008
C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 216 S COLLINS AVE | | | |
| 5. SEX FEMALE
6. RACE WHITE
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 01 09 70
9. AGE (In years last birthday) 12 17
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT
10B. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME CHARLES KNIGHT
14. MOTHER'S MAIDEN NAME KAY (SMITH) | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS ST AGNES RECORDS-BALTO MD 21229 | |
| 18. CAUSE OF DEATH
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE
 DUE TO, OR AS A CONSEQUENCE OF:
 Respiratory failure
 (B)
 DUE TO, OR AS A CONSEQUENCE OF:
 Extensive atelectasis of the lungs.
 (C) </div> <div style="width: 45%; text-align: right;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
 12 hrs. 17 min. </div> </div> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Prematurity | | | | | |
| 19A. DATE OF OPERATION 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | 21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 9 1970 to JANUARY 9 1970
that (I) (we) last saw the deceased alive on JANUARY 9 1970 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Kritha Apibunngopas M.D.
23C. PHYSICIAN'S NAME (Type) DR. KRITA | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23D. ADDRESS BALTIMORE MD 21229
ST AGNES HOSP WILKENS & CATON AVES | | 23B. DATE SIGNED 1/12/70 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial
24B. DATE 2/18/70 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 18 1970
25B. NAME OF REGISTRAR Robert E. Tabor, M.D.
25C. FUNERAL DIRECTOR Witcher, F.H. 4101 Elmwood Ave.
ADDRESS | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 1949 | |
|---|--|--|--|--|--|
| H-431 | | | | 70 1949 | |
| BIRTH NO. | | | | 70 1949 | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| HILDEBRAND, CHARLES IRVIN | | | | FEBRUARY 16, 1970 10:45 P. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | |
| 40 ST AGNES HOSPITAL | | | | MARYLAND Baltimore 5300 | |
| 5. SEX | | | | 6. DATE OF BIRTH | |
| MALE | | | | 07 24 89 | |
| 7. RACE | | | | 9. AGE (in years last birthday) | |
| WHITE | | | | 80 | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | 11. BIRTHPLACE (State or foreign country) | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | MARYLAND | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| RETIRED | | | | U S A | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 14. MOTHER'S MAIDEN NAME | |
| Bowling Alley SELF EMPLOYED | | | | ROSE KEENE | |
| 13. FATHER'S NAME | | | | 17. INFORMANT ADDRESS | |
| WILLIAM N HILDEBRAND | | | | ST AGNES RECORDS-BALTO MD 21229 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | |
| NO | | | | 219 30 8982 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | Cuban Paralysis accident | |
| ANTECEDENT CAUSES | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Atherosclerosis, cerebral | |
| II | | | | (C) | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 19A. DATE OF OPERATION | | | | 20A. AUTOPSY? (Yes or No) | |
| 19A. DATE OF OPERATION | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21F. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 8 19 70 to FEBRUARY 16 19 70 that (I) (we) lost saw the deceased alive on FEBRUARY 16 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Carlos M. Orbegoso | | | | 2-16-70 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| CARLOS M ORBEGOSO | | | | ST AGNES HOSPITAL CATON & WILKENS AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | |
| Burial | | | | 2/20/70 | |
| 24C. NAME of CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | |
| Loudon Park Cemetery | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | |
| FEB 18 1970 | | | | Witzke, 1630 Edmondson Ave., 21228 | |
| 25C. FUNERAL DIRECTOR | | | | ADDRESS | |
| Witzke, 1630 Edmondson Ave., 21228 | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-300 | | | | 70 1950 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1950 | |
|---|---------------------------|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) CALLIE BOYD | | | | 2. DATE AND HOUR OF DEATH
Feb 12, 1970 1:20 A.M. | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
91 MONTEBELLO Hosp | | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)
A. STATE MARYLAND B. COUNTY 1608 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
91 MONTEBELLO Hosp | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER
4021 CRANSTON AVE. | | | | | |
| 5. SEX
Female | 6. RACE
Negroid | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-11-26 | 9. AGE (In years last birthday)
43 | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Mose Smith | | | | 14. MOTHER'S MAIDEN NAME
Bell Coleman | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
JOSEPH BOYD - 4021 CRANSTON AVE. | | | |
| 18. 2-25-70
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Right posterior fossa Meningeoma
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
Right posterior fossa Meningeoma
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
II | | | | | | | | | |
| 19A. DATE OF OPERATION
11-11-1969 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Meningeoma | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-11-1970 to 2-12-1970 and that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Mohammad Inayatullah | | | | M.D. DEGREE
<input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
2-12-70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
MOHAMMAD INAYATULLAH | | | | 23D. ADDRESS
MONTEBELLO HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-15-70 | | 24C. NAME OF CEMETERY or CREMATORY
Abraham Mem. Pk. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
Edna E. Bailey | | 25C. FUNERAL DIRECTOR
V. R. Bailey
ADDRESS
Kelson Filling 1348 Calhoun St. | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-235 70 1951 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1951 | |
|--|---------|--|------------------|--|------------------------------|---|--|
| BIRTH NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | WILLIAM R. BOSTON | | 2/12/70 5 38 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 33 The Johns Hopkins Hospital | | | | Maryland 1603 | | | |
| | | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
718 N. Mount Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? | | |
| Male | Negro | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 7/5/04 | 66 | U.S.A. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| MACHINE OPERATOR | | UP-TO-DATE CO. | | Pa. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Joseph Boston | | | | Ella Pritchard | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 415-01-5904 | | DOROTHY WAHAKEM | | -3528 Belle Ave | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Cardiorespiratory Arrest | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Myocardial Infarction | | | |
| II | | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | ASCVD | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | | | 4:20 AM 2/12/70 to 5:30 PM 2/12/70 | | | |
| that (I) (we) last saw the deceased alive on | | | | 19 and that in (my) (our) opinion death occurred on the date | | | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Rein Saral, M.D. | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| | | | | The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 2-17-70 | | ARBUTUS MEM. PK. | | BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 18 1970 | | V. R. BAILEY | | KELSON, F. H. | | 1348 CALHOUN ST. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

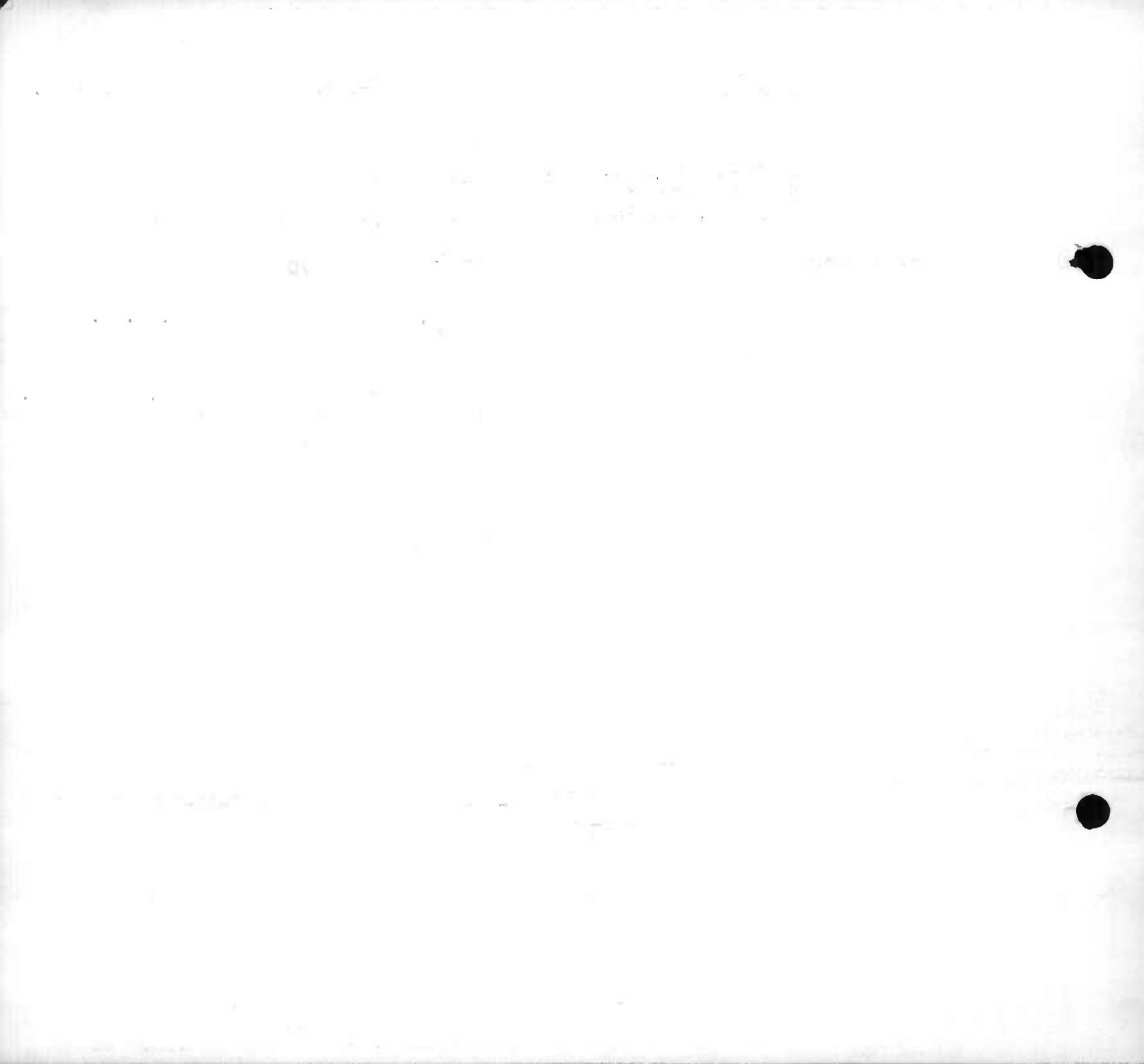
| BIRTH NO. 17-600 70 1952 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | X REG. NO. 70 1952 | |
|--|---------------------|---|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) FRANK M MURRAY | | | | 2. DATE AND HOUR OF DEATH
2-14-70 9 P.M. 5:50 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
CERTIFICATE AMENDED | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE SOUTH CAR B. COUNTY - | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE U.S.P.H.S HOSP | | | | C. CITY OR TOWN
HILTON HEAD | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| ADDRESS OR LOCATION
3100 WYMAN PARK DR
BALTIMORE, MD 21207 | | | | E. STREET AND NUMBER
POPE ROAD | | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-19-42 | 9. AGE (In years last birthday)
27 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Artist. Sanner | | 10B. KIND OF BUSINESS OR INDUSTRY
MERCHANT MARINE | | 11. BIRTHPLACE (State or foreign country)
SOUTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY
USA | |
| 13. FATHER'S NAME
ARTHUR MURRAY | | | | 14. MOTHER'S MAIDEN NAME
ANNA BELL WATSON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
281-51-9935 | | 17. INFORMANT
PATIENT | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
RESPIRATORY ARREST
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CHRONIC CELL CO OF LUNG | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
NONE | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
N/A | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
N/A | | | |
| 21D. TIME OF INJURY (APPROX.)
N/A | | 21E. INJURY OCCURRED
While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>
N/A | | 21F. HOW DID INJURY OCCUR?
N/A | | | |
| 22. I certify that (I) (his hospital) attended the deceased from APRIL 26 19 69 to FEB 13 19 70 and that (I) (we) last saw the deceased alive on FEB 13 19 70 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
John D Gelino MD | | | | 23B. DATE SIGNED
2-14-70 | | 23C. PHYSICIAN'S NAME (Type)
JOHN D GELINO MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-18-70 | | 24C. NAME OF CEMETERY or CREMATORY
Talbot Cemetery | | 24D. LOCATION (City, town, or county) (State)
Hilton Head, S.C. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
Robert F. Taylor, Jr. | | 25C. FUNERAL DIRECTOR
U.R. BAILEY | | | |
| | | | | ADDRESS
Kelso, F.H. 1348 Calhoun St. | | | |

Letter from U.S.P.H.S. Hospital
3-9-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|-----------------------------|--|---|
| J-520 70 1953 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1953 | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) S. Anna Jones | | 2. DATE AND HOUR OF DEATH
2-15-70 EOR 3:35 p.m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 1702 | | 5. CITY OR TOWN Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
39
Provident Hospital Inc.
1514 Division Street
Baltimore, Maryland 21217 | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
Key Circle Hospital 1214 Eutaw Place | |
| 6. SEX
Female | 7. RACE
Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. DATE OF BIRTH
6-19-91 | 10. AGE (In years last birthday)
78 | 11. If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Pa. | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
William Smith | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
215-16-5996 | | 17. INFORMANT
Bernice Burton-daugh. Ave.
Mrs Gazelle Barnes (Daughter) 827 Arlington | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Parkinson's Disease | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
Heart Failure
DUE TO, OR AS A CONSEQUENCE OF:
(B) myocardial Infarction - fibrillation
DUE TO, OR AS A CONSEQUENCE OF:
(C) fibrillation | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-15-70 19 to 2-15-70 19 that (I) (we) last saw the deceased alive on 2-15-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William Johnson M.D. | | 23B. DATE SIGNED
2/17/70 | | 23C. PHYSICIAN'S NAME (Type)
DEGREE | |
| 23D. ADDRESS | | 23E. PHYSICIAN'S NAME (Type)
DEGREE | | 23F. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
Burial 2-20-70 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 24E. DATE RECEIVED BY HEALTH DEPT.
FEB 18 1970 | | 24F. NAME OF REGISTRAR
V.R. Bailey | |
| 24G. FUNERAL DIRECTOR
Kelson, F.H. | | 24H. ADDRESS
1348 Calhoun | | 24I. ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-200 70 1954 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1954 | |
|--|--|--|--|---|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print) OSCAR SUGGS | | 2. DATE AND HOUR OF DEATH
2/16/70 3 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
A. STATE MARYLAND B. COUNTY 1538 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
42 SINAI HOSP. Balto. | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX M 6. RACE N N | | E. STREET AND NUMBER
2305 ALLENDALE RD #16 | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 8. DATE OF BIRTH
1/12/95 | | 9. AGE (In years last birthday) 75 | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Isaac Suggs | | 14. MOTHER'S MAIDEN NAME
Thay | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO.
245-48-8114A | | 17. INFORMANT ADDRESS
Alberta Lofton - 2305 Allendale | | | |
| 18. 5 P 2 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Pneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) Chronic renal disease | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | Arteriosclerotic Heart disease | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/5/70 19 to 2/16/70 19 that (I) (we) last saw the deceased alive on 2/16/70 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. McVerry MD | | 23B. DATE SIGNED
2/16/70 | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS | | 23E. DEGREE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-21-70 | | 24C. NAME of CEMETERY or CREMATORY
Church Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Greenville, N.C. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | | |
| 25B. NAME OF REGISTRAR
John E. Taylor, R.D. | | 25C. FUNERAL DIRECTOR
V. R. Bailey | | | |
| 25D. ADDRESS
1348 Calhoun St. | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1955 | |
|--|------------------|---|-----------------------------|--|---|
| J-525 70 1955 | | BIRTH NO. | | 70 1955 | |
| 1. NAME OF DECEASED
(Type or Print) Johnson, Andrew | | 2. DATE AND HOUR OF DEATH
2-17-70 4:45 A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
39
Provident Hospital
1514 Divison Street
Baltimore, Maryland 21217 | | A. STATE
Maryland
C. CITY OR TOWN
Baltimore
E. STREET AND NUMBER
2229 Brookfield Ave. | | B. COUNTY
1302
D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-31-14 | 9. AGE (In years last birthday) 55 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Texco Gas Co. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
N. C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Joseph Johnson | | 14. MOTHER'S MAIDEN NAME
Grace Pernell | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
239-01-9335 | | 17. INFORMANT
James Johnston-bro
Mr. Rochester-Nephew
Address 526 Beaumont Ave.
1844 Carrollton Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Shock, Irreversible | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Intracerebral Hemorrhage
(B) Hypertensive Cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initial medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-7-70 19 to 2-17-70 19 that (I) (we) last saw the deceased alive on 2-17-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
G. Tengco MD. | | 23B. DATE SIGNED
Feb. 17, 1970 | | | |
| 23C. PHYSICIAN'S NAME (Type)
G. Tengco MD. | | 23D. ADDRESS
1514 Divison Street Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-22-70 | | 24C. NAME OF CEMETERY OR CREMATORY
Family Cemetery | |
| 24D. LOCATION
Weldon, North Carolina | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
V. R. Bailey | | 25D. ADDRESS
1346 N. Calhoun St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | REG. NO. 70 1956 | |
|---|---------------------|--|------------------------------------|---|---|
| C-636 70 1956 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Dorothy M. Carter</i> | | 2. DATE AND HOUR OF DEATH
<i>2-10-70 11:20</i> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>2506</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>South Batto. Gen Hosp</i>
<i>43</i> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN
<i>Baltimore</i> | |
| | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
<i>3461 Childs Ct</i> | |
| 5. SEX
<i>F</i> | 6. RACE
<i>C</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>3/24/27</i> | 9. AGE (In years last birthday)
<i>42</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Sales</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Nassau, Bahamas</i> | |
| 13. FATHER'S NAME
<i>Eustace Johnson</i> | | 14. MOTHER'S MAIDEN NAME
<i>Ollie Thompson</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>220-36-2262</i> | | 17. INFORMANT
<i>INEZ WYMAN - 1843 E. 30th St.</i> | |
| 18. <i>174X1</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
<i>Metastatic Ca lung</i> | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Duct cell Carcinoma? left Breast</i> | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| 19B. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>None</i> | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | |
| 19A. DATE OF OPERATION
<i>5-1969</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Carcinoma left breast</i> | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>4/12/69</i> to <i>2/11/70</i> , that (I) (we) last saw the deceased alive on <i>2/3/70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>George S. Tan</i> | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type)
<i>George S. Tan</i> | |
| 23D. ADDRESS
<i>4306 Belle Grove Rd</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>2-16-70</i> | |
| 24C. NAME OF CEMETERY or CREMATORY
<i>ST FRANCIS XAVIER Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>NASSAU, BAHAMA</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>B 18 1970</i> | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>Robert E. Taylor</i> | | 25D. ADDRESS
<i>1345 Calhoun St.</i> | |

BIRTH NO.

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|--|--|---|--|-------------------|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) | | | | | | 2. DATE OF DEATH | | | | | | 3. DATE PRONOUNCED DEAD | | | | | |
| GORDON REID | | | | | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | | | | | | Month Day Year Hour | | | | | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | | | February 14, 1970 | | | | | | 9:50 P. M. | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | | | | | | | | |
| 38 University Hospital | | | | | | | | | | | | | | | | | |
| 6. SEX | | 7. RACE | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | | | | | | | | | |
| Male | | Negro | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday) | | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | E. STREET AND NUMBER | | | | | | | | | | | |
| 3-21-56 | | 13 | | | | 407 Ilchester | | | | | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | | | | | | | | | | |
| Md. | | | | U.S.A. | | Adrain Reid | | | | | | | | | | | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| student | | | | | | Delores Toyer | | | | | | | | | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT | | | | ADDRESS | | | | | | | |
| no | | | | none | | Adrain & Delores Reid | | | | 407 Ilchester Ave | | | | | | | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | CAUSE OF DEATH | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | | | | Gunshot wound of back | | | | | |
| ANTECEDENT CAUSES | | | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | | (c) | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | | | | | | | | | | | |
| 20A. DATE OF OPERATION | | | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 21. AUTOPSY? (Yes or No) | | | | | | | | | |
| 2 | | | | | | | | Yes | | | | | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 22C. WHERE DID IT INJURY OCCUR? (if in Baltimore City, give exact location) | | | | | | | | | |
| | | | | house | | | | 206 N. Fremont Ave. 2nd floor | | | | | | | | | |
| 22D. TIME OF INJURY (Approx.) | | | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 22F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 2-14-70 8:55 P. | | | | m. | | | | ? | | | | | | | | | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | Charles S. Springate, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | | Charles S. Springate, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | February 15, 1970 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | | | |
| Burial | | | | 2-19-70 | | | | Mt. Auburn Cem. | | | | Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR V. Bailey | | | | ADDRESS | | | | | |
| FEB 18 1970 | | | | Robert E. Fisher, M.D. | | | | Kelson F.H. | | | | 1348 Calhoun Street | | | | | |

Job 54

1. The first part of the report is a general description of the project. This includes the objectives, the scope of the work, and the methods used. The second part is a detailed description of the results of the work. This includes a discussion of the data collected, the analysis of the data, and the conclusions drawn from the data. The third part is a summary of the work. This includes a brief overview of the project, the results, and the conclusions.

| ACADEMY ROAD | |
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1958

BIRTH NO.

| | | | | |
|--|-------------------------|---|--|--|
| 1. NAME OF DECEASED
(Type or Print)
VINCENT C. JACKSON | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year
February 14, 1970 | | Hour
M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
1302 Stockton Street | | 3. DATE PRONOUNCED DEAD
Month Day Year
February 14, 1970 | | Hour
6:55 P. |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland | | B. COUNTY
1501 | | |
| 6. SEX
Male | 7. RACE
Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore |
| 9. DATE OF BIRTH
5-31-12 | | 10. AGE (In years last birthday)
57 | | E. STREET AND NUMBER
1302 Stockton Street |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF
U.S.A. | | 13. FATHER'S NAME
Phillip Jackson |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
baker | | 14B. KIND OF BUSINESS OR INDUSTRY | | 15. MOTHER'S MAIDEN NAME |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Gertrude Jackson |
| 19. 412.4 | | CAUSE OF DEATH
Arteriosclerotic cardiovascular disease | | ADDRESS
4940 Denmore Ave. |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No)
Yes |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Springate M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED February 15, 1970 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-20-70 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | |
| 25B. NAME OF REGISTRAR
Robert E. [Signature] | | 25C. FUNERAL DIRECTOR
V. Baile
Welson F.H. 1348 Calhoun St. | | |

ACADEMY BOND

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 69-08701

REG. NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
Shontae Melissa Downes | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION
42 Sinai Hospital
4-2-71 | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
2 16 70 10:50 a.m. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 1303 | | 6. SEX female
7. RACE colored
B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 9. DATE OF BIRTH
5-16-69 | | 10. AGE (In years last birthday)
9
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF
USA | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
Denise Downes | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Mr. Regenold Smith 824 N. Mount Street | |
| 19. 4857
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Bronchopneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) IMMEDIATE CAUSE (SDII) Interstitial pneumonitis
DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Werner U. Spitz M.D.
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
Deputy Chief Medical Examiner
DATE SIGNED 2/17/70 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-20-70 | |
| 24C. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore Co., Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
E. J. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
Nutter Funeral Home | | ADDRESS
3035 W. North Ave. | |

Letter from M.E.'s office

4-2-71

M.H.

ACADEMY BOND

IN CONTENT

WORTHY PAPER OF

U.S.A.

NO. 1075

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 1960

| | | | |
|---|--|---|--|
| F-200 70 1960 | | BIRTH NO. | |
| 1. NAME OF DECEASED
(Type or Print)
<u>Fooks, Lillian G.</u> | | 2. DATE AND HOUR OF DEATH
<u>2-14-70</u> <u>13:40 A.</u> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Provident Hospital</u> | | A. STATE
<u>Maryland</u> | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | B. COUNTY
<u>1602</u> | |
| 5. SEX
<u>F</u> | | C. CITY OR TOWN
<u>Baltimore</u> | |
| 6. RACE
<u>Negro</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER
<u>1140 N Stricker St</u> | |
| 8. DATE OF BIRTH
<u>2/19/89</u> | | 9. AGE (In years last birthday)
<u>80</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore</u> | |
| 10B. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>US</u> | |
| 13. FATHER'S NAME
<u>Arthur L. Fooks</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lillian G. Johnson</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>217-14-0339J1</u> | |
| 17. INFORMANT
<u>Mr. Eugene Fooks</u> | | ADDRESS
<u>1140 N. Stricker St.</u> | |
| 18. <u>4369</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Cerebrovascular Accident</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
<u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>January 13,</u> 19 <u>70</u> to <u>February 14,</u> 19 <u>70</u>
that (I) (we) last saw the deceased alive on <u>February 14,</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<u>Raymundo R. Corpuz, M.D.</u> | | 23B. DATE SIGNED
<u>2-14-70</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Raymundo R. Corpuz, M.D.</u> | | 23D. ADDRESS
<u>1514 Division Street Baltimore, Maryland 21217</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2-19-70</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY
<u>Arbutus Memorial Park</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore Co., Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 18 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, Jr.</u> | |
| 25C. FUNERAL DIRECTOR
<u>Nutter Funeral Home</u> | | ADDRESS
<u>3035 W. North Avenue</u> | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1961 | |
|--|------------------|---|---|--|---|
| BIRTH NO. 4-125 70 1961 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print)
HOPSON, Ethel | | | 2. DATE AND HOUR OF DEATH
2/16/70 5:30 P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
33 The Johns Hopkins Hospital
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 833
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER
2417 E. Biddle Street | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/18/17 | 9. AGE (In years last birthday)
52 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
- | 11. BIRTHPLACE (State or foreign country)
Va | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
William Epps | | | 14. MOTHER'S MAIDEN NAME
Alice Duncan | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
Joseph Hopson 2417 E. Biddle St.
ADDRESS | | |
| 18. 23 0191 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE (probable) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF:
(B) diabetes, H.A.S.C.V.D.
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. (DOR) | | | | | |
| 23A. SIGNATURE
James L. Bolen | | | 23B. DATE SIGNED
2/17/70 | | 23C. PHYSICIAN'S NAME (Type)
James L. Bolen, M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
2/20/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | | 25B. NAME OF REGISTRAR
James E. [unclear] | | 25C. FUNERAL DIRECTOR
James E. [unclear] 1129 N. Carroll St. |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | | 70 1962 | |
|---|-------------------------|---|--------------------------------------|---|---|--|--|
| BIRTH NO. 3-260 70 1962 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Geiser, Robert H. | | | | 2. DATE AND HOUR OF DEATH
2/16/70 2⁰⁰ A. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
The Johns Hopkins Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Pennsylvania, Franklin
B. COUNTY V-35
C. CITY OR TOWN Waynesboro
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER P.O. Box 383 | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/11/1903 | 9. AGE (In years last birthday)
67 | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Public Utilities | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Philadelphia Pa. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Harry Geiser | | | | 14. MOTHER'S MAIDEN NAME
May S. Nicodemus | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
178-16-4186 | | 17. INFORMANT ADDRESS
Mrs. Grace W. Geiser, Waynesboro Pa. Box 383 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
796.91 | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
G-I bleeding | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
36 hours | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Probable Curling's ulcer | | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
Steroid therapy | | 36-48 hours | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Renal insufficiency | | | | | | | |
| 19A. DATE OF OPERATION
1-21-70 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
hiatal hernia - repeated aspiration | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (A) (this hospital) attended the deceased from 1/17 19 70 to 2/16 19 70 , that (B) (we) lost saw the deceased alive on 2/16/70 19 70 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Paul L. Tecklenberg MD | | | | 23B. DATE SIGNED
2/16/70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
PAUL L. Tecklenberg MD | | | | 23D. ADDRESS
601 N. Broadway, Box 161
Baltimore MD. 21205 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/19/70 | | 24C. NAME OF CEMETERY or CREMATORY
Green Hill | | 24D. LOCATION (City, town, or county) (State)
Waynesboro, Franklin Co. Pa. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
David E. J. J. J. | | 25C. FUNERAL DIRECTOR
David E. J. J. J. | | ADDRESS
Waynesboro Pa. | |

26 June
26 June
14 July

GI Bleeding
Fishes: Cautious about
Stomach empty
Food disappearing

① 2-10-10
② 2-10-10

③ 2-10-10
④ 2-10-10

2/11/10
2/11/10
2/11/10

2/11/10

2/11/10
2/11/10
2/11/10

2/11/10
2/11/10
2/11/10

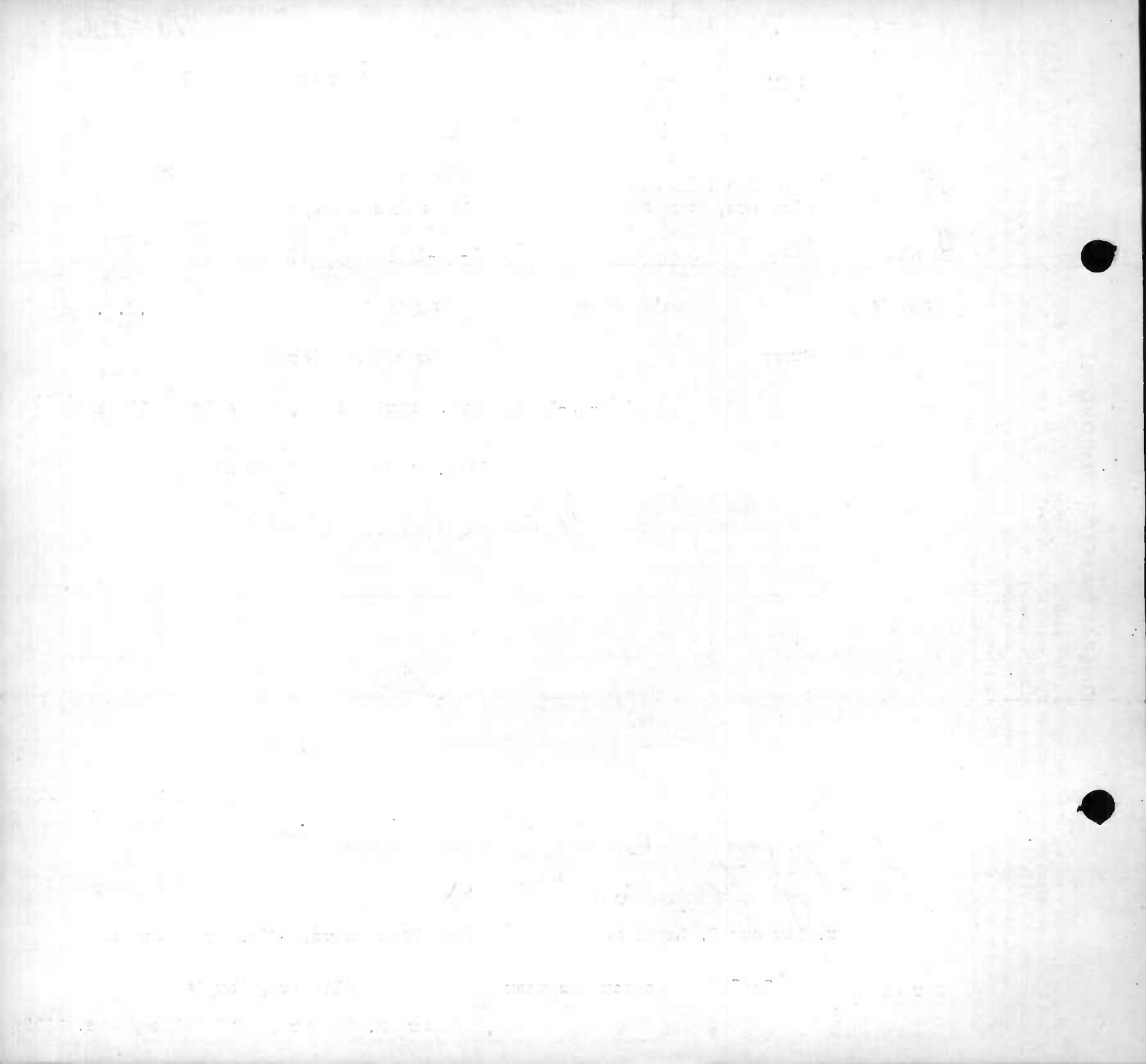
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1963 | |
|---|---|---|---|--|--|
| <div style="display: flex; justify-content: space-between;"> G-620 70 1963 </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) EDITH GROSS | | | 2. DATE AND HOUR OF DEATH
February 15, 1970 11¹⁰ P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 27 Oaklee Village
Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 2551
C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 27 Oaklee Village | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2- 8-1893 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Saleslady | | | 10B. KIND OF BUSINESS OR INDUSTRY
Rice's Bakery | | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
August Gross | | |
| 14. MOTHER'S MAIDEN NAME
Ernestine Warni | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO.
214-03-2999 | | | 17. INFORMANT ADDRESS
Mrs. Carrie Davis, 27 Oaklee Village 21229 | | |
| 18. 4/12/71 I I CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Congestive heart failure
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerotic CVD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/15 1966 to 2/15 1970 , that (I) (we) last saw the deceased alive on 2/15 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Herbert J. Levickas M.D. | | | | 23B. DATE SIGNED
2/16/70 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Herbert J. Levickas | | | | 23D. ADDRESS
5404 East Drive, Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-19-70 | | 24C. NAME of CEMETERY or CREMATORY
Western Cemetery | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1964 | |
|--|---|--|---|--|---|
| <div style="font-size: 1.5em; float: left;">M-325</div> <div style="font-size: 2em; float: left; margin-left: 10px;">70</div> <div style="font-size: 1.5em; float: left; margin-left: 10px;">1964</div> <div style="clear: both;"></div> | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. 1 | | | | | |
| 1. NAME OF DECEASED
(Type or Print) MILDRED C. MADISON | | | 2. DATE AND HOUR OF DEATH
February 15, 1970 M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 2541 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00 563 Thornfield Road
Baltimore, Maryland | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
563 Thornfield Road | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-17-1916 | 9. AGE (In years last birthday)
54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tailor | | 10B. KIND OF BUSINESS OR INDUSTRY
Haas Tailoring Co. | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Benjamin Chaffman | | | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
215-24-1039 | | 17. INFORMANT
Mr. Anthony J. Madison, 563 Thornfield Rd. | | | |
| 18. 157.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
Terminal Ca
(B) DUE TO, OR AS A CONSEQUENCE OF:
Ca of pancreas
(C)..... | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 to 2.15.1970 , that (I) (we) lost saw the deceased alive on 2.15.1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Stanley Ankudas DEGREE | | | | 23B. DATE SIGNED
2.16.70 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Stanley Ankudas | | | | 23D. ADDRESS
1101 Maiden Choice Lane, Balto., Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-18-70 | | 24C. NAME of CEMETERY or CREMATORY
Most Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 24E. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 18 1970 | | 25B. NAME OF REGISTRAR
J. E. Kelly, Jr. | | 25C. ADDRESS | |

James H. Brown
James H. Brown

James H. Brown
James H. Brown

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70-1965</u> | |
|---|--|--|--|---|--|
| M-250 70 1965 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. <u>70-02513</u> | | | 2. DATE AND HOUR OF DEATH
<u>2-8-70</u> <u>8:45</u> a.m. | | |
| 1. NAME OF DECEASED
(Type or Print) <u>MASON, BABY BOY, CYRENNIA</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>907</u> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>31 Eastern Avenue</u>
<u>Baltimore, Maryland</u>
<u>BALTIMORE CITY HOSPITALS</u> <u>21224</u> | | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | E. STREET AND NUMBER <u>2643 Kennedy Avenue Apt. 5</u> <u>21218</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) | | | 8. DATE OF BIRTH <u>1-30-70</u> 9. AGE (In years last birthday) <u>9</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME <u>Cyrenna V. Bustion</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT <u>4940 Eastern Avenue</u> ADDRESS <u>BCH: Records Baltimore, Maryland 21224</u> | | | | | |
| 18. <u>743.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE <u>Cardio-vascular</u> DUE TO, OR AS A CONSEQUENCE OF:
(B) _____ DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<u>Encephalocoele</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <u>2-2-70</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Encephalocoele</u> | | | 20A. AUTOPSY? (Yes or No) <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-30</u> 19 <u>70</u> to <u>2-8</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2-8</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>G. T. Miyazono</u> | | | 23B. DATE SIGNED <u>2-9-70</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>G. Miyazono</u> MD | | | 23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland</u> <u>BALTIMORE CITY HOSPITALS</u> <u>21224</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATED</u> | | 24B. DATE <u>2-16-70</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Baltimore City Hospital</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Maryland, 21224</u> | | 24E. NAME of REGISTRAR <u>Robert E. Faber, Jr.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 18 1970</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Faber, Jr.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|---|---|
| <div style="display: flex; justify-content: space-between;"> L-532 70 1966 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | REG. NO. 70 1966 | |
| BIRTH NO. _____
1. NAME OF DECEASED
(Type & Print) <i>Josephine M. Lewandowski</i> | | 2. DATE AND HOUR OF DEATH
<i>2/17/70</i> <i>6⁵⁰ P M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<i>Maryland General Hosp</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>604</i>
C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>221 Washington St.</i> | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11/1/93</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>CROWN, CORK SEAL</i> | 9. AGE (in years last birthday) <i>77</i>
If Under 1 Yr. Months Days Hours Min.
If Under 24 Hrs. Min. |
| 11. BIRTHPLACE (State or foreign country)
<i>Poland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Frank Wiatrowski</i> | | 14. MOTHER'S MAIDEN NAME
<i>Maryanna Cyganek</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>214-14-3001</i> | 17. INFORMANT
<i>Chart</i> |
| 18. <i>418.41</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardio-Respiratory Arrest</i>
(B) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<i>Diverticulosis</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
<i>None</i> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
<i>Yes</i> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/6/70</i> 19 to <i>2/17/70</i> 19 that (I) (we) last saw the deceased alive on <i>2/17/70</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>J. J. Oldroyd M.D.</i> | | 23B. DATE SIGNED
<i>2/17/70</i> | 23C. PHYSICIAN'S NAME (Type)
<i>J. J. Oldroyd M.D.</i> |
| 23D. ADDRESS
<i>Maryland General Hospital</i> | | 23E. ATTENDING PHYSICIAN: Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | 24B. DATE
<i>2/21/70</i> | 24C. NAME OF CEMETERY OR CREMATORY
<i>ST. STANISLAUS</i> | 24D. LOCATION (City, town, or county) (State)
<i>DUNDALK MD.</i> |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 19 1970</i> | 25B. NAME OF REGISTRAR
<i>John M. Wabersky</i> | 25C. FUNERAL DIRECTOR
<i>John M. Wabersky & Sons</i> | |
| ADDRESS
<i>401 S. Chester St.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | |
|---|--|---|--|---|------------------------------|
| K-410 | | 70 1967 | | 70 1967 | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Kolb MARGARET | | 15 Feb 70 1:45 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | | | |
| University of Maryland Hosp | | MD BALTIMORE | | 2735 | |
| | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER | | | |
| | | 3306 E Northern Pkwy | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| F | W | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11/6/66 | 63 | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | WISCONSIN | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| William Lauterbach | | Bertha Keck | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | HUSBAND Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | Cerebello-Pontine angle Brain tumor | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| Feb 70 | BRAIN tumor | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office Bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. Certify that (I) (this hospital) attended the deceased from 29 JAN 19 70 to 15 Feb 19 70 and that (I) (we) lost saw the deceased alive on 15 Feb 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Edward D. Hayne MD | | 15 Feb 70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Edward D. Hayne MD | | University of Maryland Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 2/18/70 | St Johns | Anndale Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| FEB 19 1970 | John E. Fisher, Jr. | Ed. E. E. E. 6067 Bayford Rd | | | |

FUNERAL DIRECTOR: IMPORTANT

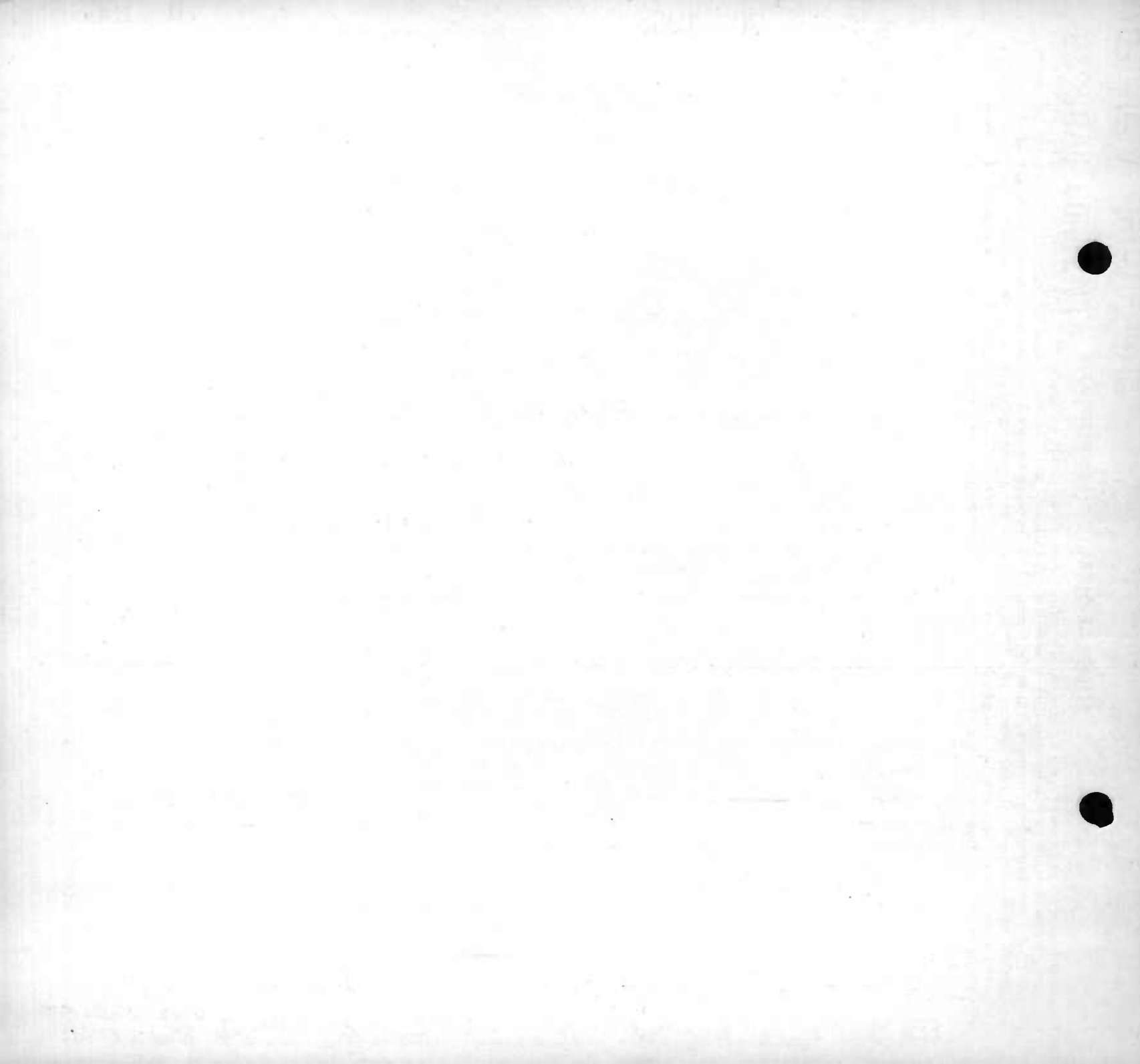
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> F-535 70 1968 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div> | | 70 1968
REG. NO. _____ | |
| 1. NAME OF DECEASED
(Type or Print) IDA TERESSA FOUNTAIN | | 2. DATE AND HOUR OF DEATH
2/18/70 18:30 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UPBANDS HOME FOR CHURCH WOMEN | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MD B. COUNTY BALTIMORE
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 4501 OLD FREDERICK RD | |
| 5. SEX F | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/25/78 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher | | 10B. KIND OF BUSINESS OR INDUSTRY
School | |
| 11. BIRTHPLACE (State or foreign country)
Kent Co. Md | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
CHARLES ALBERT FOUNTAIN | | 14. MOTHER'S MAIDEN NAME
IDA GOLD SMITH | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
218-46-9896 | 17. INFORMANT
ISABELLE P. KANGLEY ADDRESS 4501 Old Frederick |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

acute myocardial infarction
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

ASCVD, generalised
(B) DUE TO, OR AS A CONSEQUENCE OF: | | many years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
none | | | |
| 19A. DATE OF OPERATION
none | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 1955 to 18 FEB 1970 , that (I) (we) last saw the deceased alive on 11 Feb 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
[Signature] DEGREE | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | 23B. DATE SIGNED
18 Feb 70 |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 24B. DATE
2- 1970 | 24C. NAME OF CEMETERY or CREMATORY
Mt. Olivet | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | 25B. NAME OF REGISTRAR
Robert E. Taylor, MD | 25C. FUNERAL DIRECTOR
Wm Cook-Brooks West, 6212 Baltimore Ave, Baltimore, Md. | |



1

5-426 70 1969 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1969

BIRTH NO.

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED JEAN BETTY SILZER
(Type or Print) | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Union Memorial Hospital (DOA) 2-21-70 | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
2 15 70 9:15 P.M. | |
| 6. SEX
Female | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
30 JUNE 1917 | | 10. AGE (In years lost birthday)
52 | |
| 11. BIRTHPLACE (State or foreign country)
NEBRASKA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HERBERT J. MANN | | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Md. | |
| 15. MOTHER'S MAIDEN NAME | | B. COUNTY
1307 | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)
NO | | 17. SOCIAL SECURITY NO.
184-10-5756 | |
| 18. INFORMANT
W.R. JILZER | | ADDRESS
2529 MEREDITH DRIVE VIENNA, VA. | |
| 19. E 9 5 7 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF:

(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION
2 | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
yes | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
bldg. | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
500 W. University Pkwy. 1307 | | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour)
2-15-70 ? | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subj. jumped from roof. | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>

ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D.
EXAMINER'S NAME (Type)

DATE SIGNED
2-16-70 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL/REMOV. | | 24B. DATE
2-17-70 | |
| 24C. NAME OF CEMETERY or CREMATORY
FLINT HILL CEMETERY | | 24D. LOCATION (City, town, or county) (State)
OAKTON, VIRGINIA | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | |
| 25C. FUNERAL DIRECTOR
ULRICH FUNERAL HOME, INC. | | ADDRESS
BALTO FOR MONEY KING VIENNA, VA. | |

VS 151-REV. 7/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

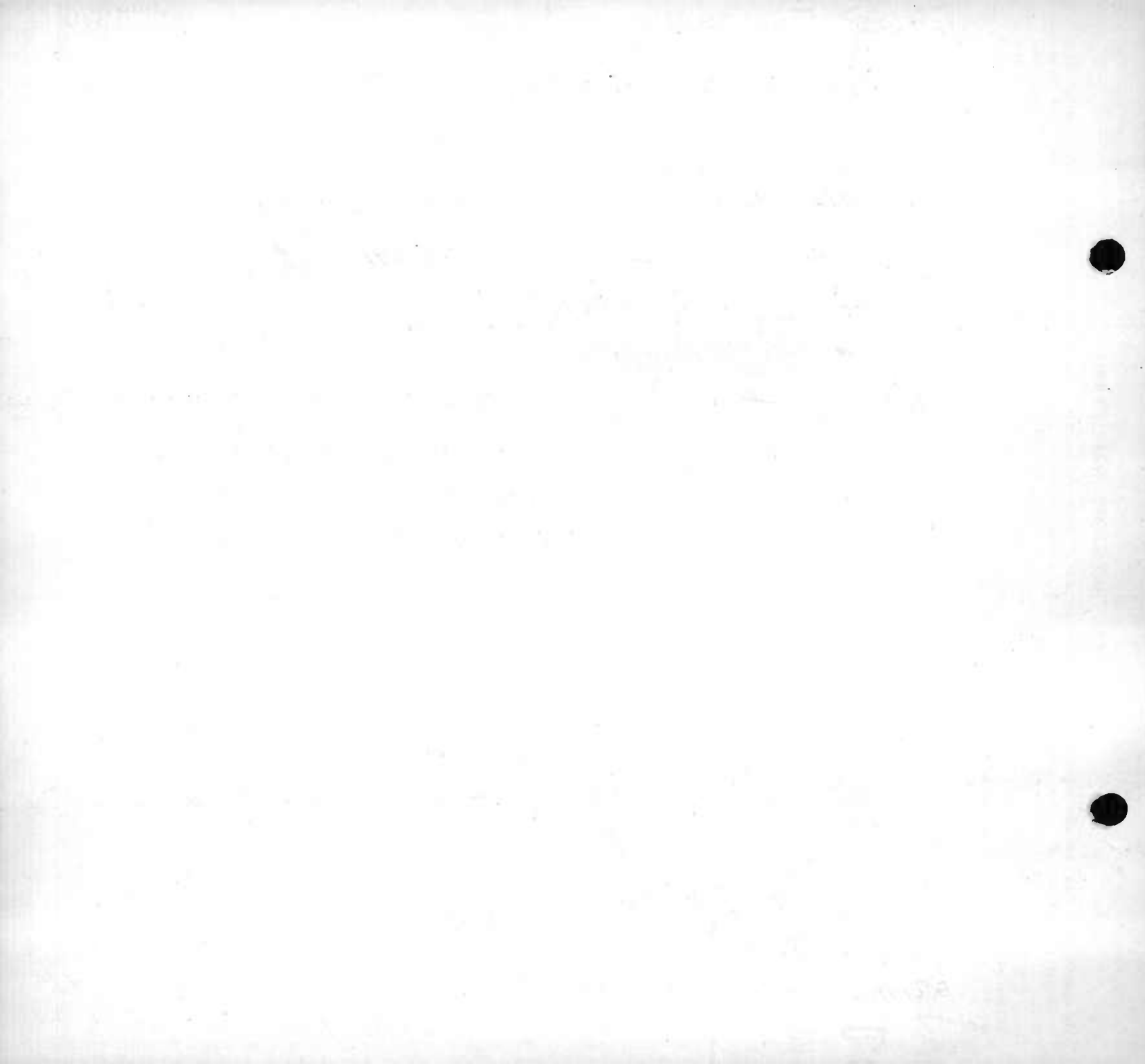
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1970 | |
|--|--|--|--|---|--|
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print) FRANK X. MAIER | | 2. DATE AND HOUR OF DEATH
2/14/70 3:00 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
00 319 E. 29TH ST. BALTO, Md | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY 1203

C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

E. STREET AND NUMBER 319 E. 29TH ST. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8/23/1891 | 9. AGE (In years last birthday) 78 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
chef | | 10B. KIND OF BUSINESS OR INDUSTRY
RESTAURANT | | 11. BIRTHPLACE (State or foreign country)
Germany | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
Frank X Maier | | | |
| 14. MOTHER'S MAIDEN NAME
Sarah Reading | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | |
| 16. SOCIAL SECURITY NO.
214-14-0339 | | 17. INFORMANT MRS. Gertrude Mitchell ADDRESS 218 E. PRESTON ST. 21202 | | | |
| 18. CAUSE OF DEATH
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 410.9 I
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

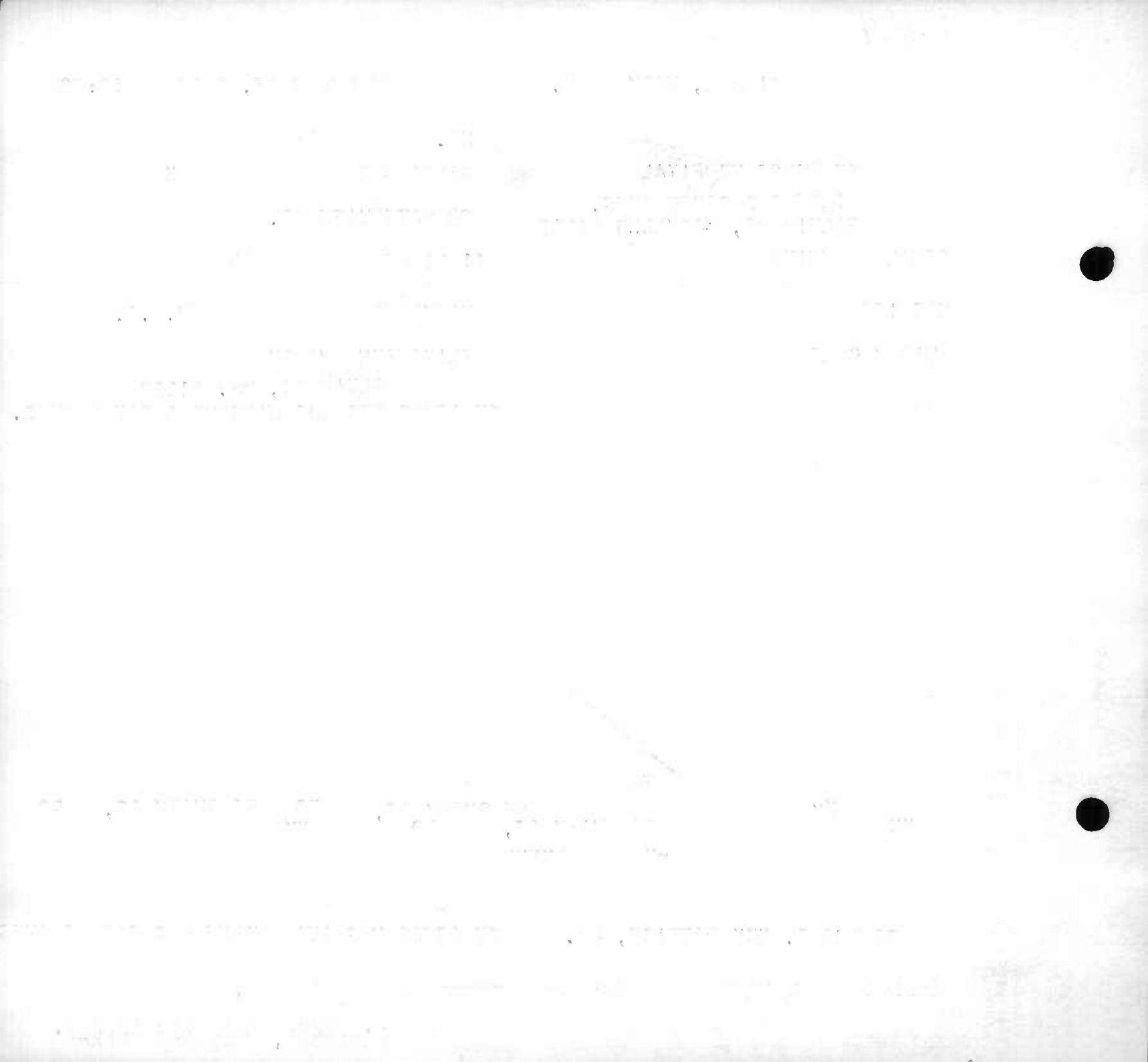
 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> Atherosclerotic Heart Disease
 (A) IMMEDIATE CAUSE
 DUE TO, OR AS A CONSEQUENCE OF:
 acute MI & failure
 (B) genit. arteriosclerosis
 DUE TO, OR AS A CONSEQUENCE OF:
 (C) </div> <div style="width: 45%; border-left: 1px solid black; padding-left: 5px;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1 19 70 to Feb 14 19 70, that (I) (we) last saw the deceased alive on Feb 12 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Donald W. Mintzer DEGREE | | | | 23B. DATE SIGNED
Feb 14 1970 | |
| 23C. PHYSICIAN'S NAME (Type)
DONALD W. MINTZER DEGREE | | | | 23D. ADDRESS
3009 EVERGREEN AVE BALTIMORE Md 21214 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2/17/70 | | 24C. NAME OF CEMETERY or CREMATORY
LORRAINE PK Cem | |
| 24D. LOCATION (City, town, or county) (State)
BALTO Md | | 25A. DATE REC'D BY HEALTH DEPT
FEB 19 1970 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR E. S. Mace Nable ADDRESS 301 Fredrick Rd | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|---|--|
| F-634 70 1971 BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH X REG. NO. 70 1971 | |
| 1. NAME OF DECEASED
(Type or Print) FRIEDEL, MARY M. | | 2. DATE AND HOUR OF DEATH
FEBRUARY 15, 1970 10:00P <small>M.</small> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
40 ST AGNES HSPITAL WILKENS & CATON AVES. BALTIMORE, MARYLAND 21229 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY Anne Arundel 52-00 | |
| 5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11 21 05 9. AGE (In years last birthday) 64 10. Under 1 Yr. Months 11. Under 24 Hrs. Days 12. Under 24 Hrs. Hours 13. Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HARRY COLE | | 14. MOTHER'S MAIDEN NAME ELIZABETH WALSH | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT BALTIMORE, MD. 21229 | | 18. ADDRESS ST AGNES RECORDS WILKENS & CATON AVES. | |
| 18. CAUSE OF DEATH
I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Myocardial Damage (infarction)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Coronary Occlusion
ASCVD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that XX (this hospital) attended the deceased from FEBRUARY 15, 1970 to FEBRUARY 15, 1970 that XX (we) last saw the deceased alive on FEBRUARY 15, 1970 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) saw the body after death. | | | |
| 23A. SIGNATURE <i>George S. Patrick</i> | | 23B. DATE SIGNED 2-15-70 | |
| 23C. PHYSICIAN'S NAME (Type) GEORGE S. XXX PATRICK, MD. | | 23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATONS AVES | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/19/70 | |
| 24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 19 1970 | | 25B. NAME OF REGISTRAR <i>Robert E. J. J. J.</i> | |
| 25C. FUNERAL DIRECTOR George J. Gonce | | ADDRESS 4001 Ritchie Hwy. Baltimore, Maryland 21225 | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 1972

BIRTH NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED <u>Kathryn F. JESMER</u>
(Type or Print) | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year
Estimated <input type="checkbox"/> Feb. 14, 1970 | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
403 Annabel Ave. | | 3. DATE PRONOUNCED DEAD
Month Day Year
February 14, 1970 12:55 A.M. | |
| 6. SEX
Female | | 7. RACE
White | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
Feb. 19, 1952 | | 10. AGE (in years lost birthday)
17 1/2 | |
| 11. BIRTHPLACE (State or foreign country)
Delaware | | 12. CITIZEN OF
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 14B. KIND OF BUSINESS OR INDUSTRY | |
| 15. MOTHER'S MAIDEN NAME
Virginia K. Smith | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Mrs. Virginia Kimmons | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Hanging
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Home | |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
403 Annabel Ave. 25-34 | | 22D. TIME OF INJURY (APPROX.)
Feb. 13 or 14, 1970 | |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Hanged self | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 2-14-70 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/17/70 | |
| 24C. NAME OF CEMETERY or CREMATORY
Meadowridge Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Elkridge, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | 25B. NAME OF REGISTRAR
Robert E. Harvey, R.D. | |
| 25C. FUNERAL DIRECTOR
George J. Gonce | | ADDRESS
4001 Ritchie Hwy. Baltimore, Md. 21225 | |

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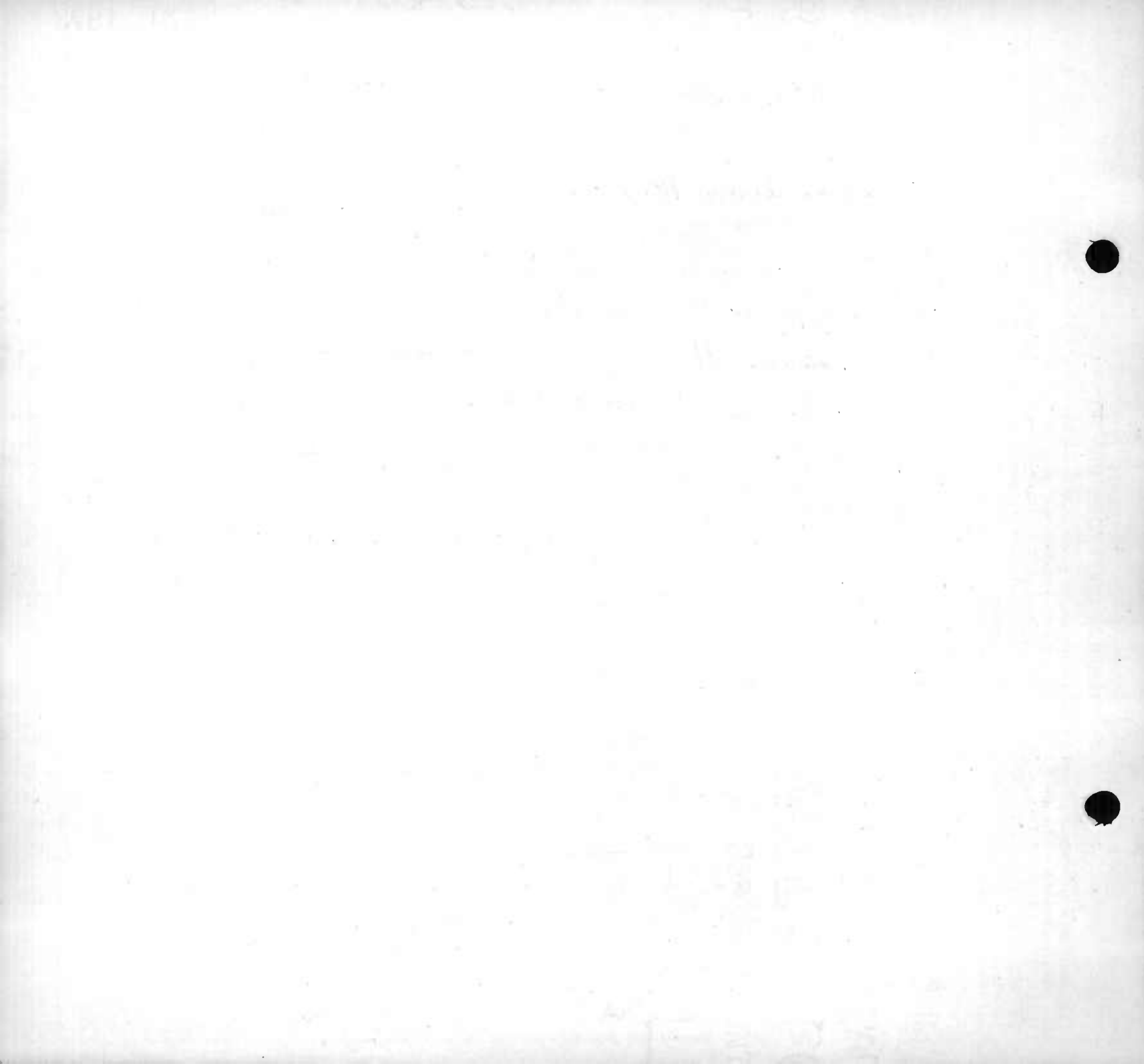
1971

1972

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

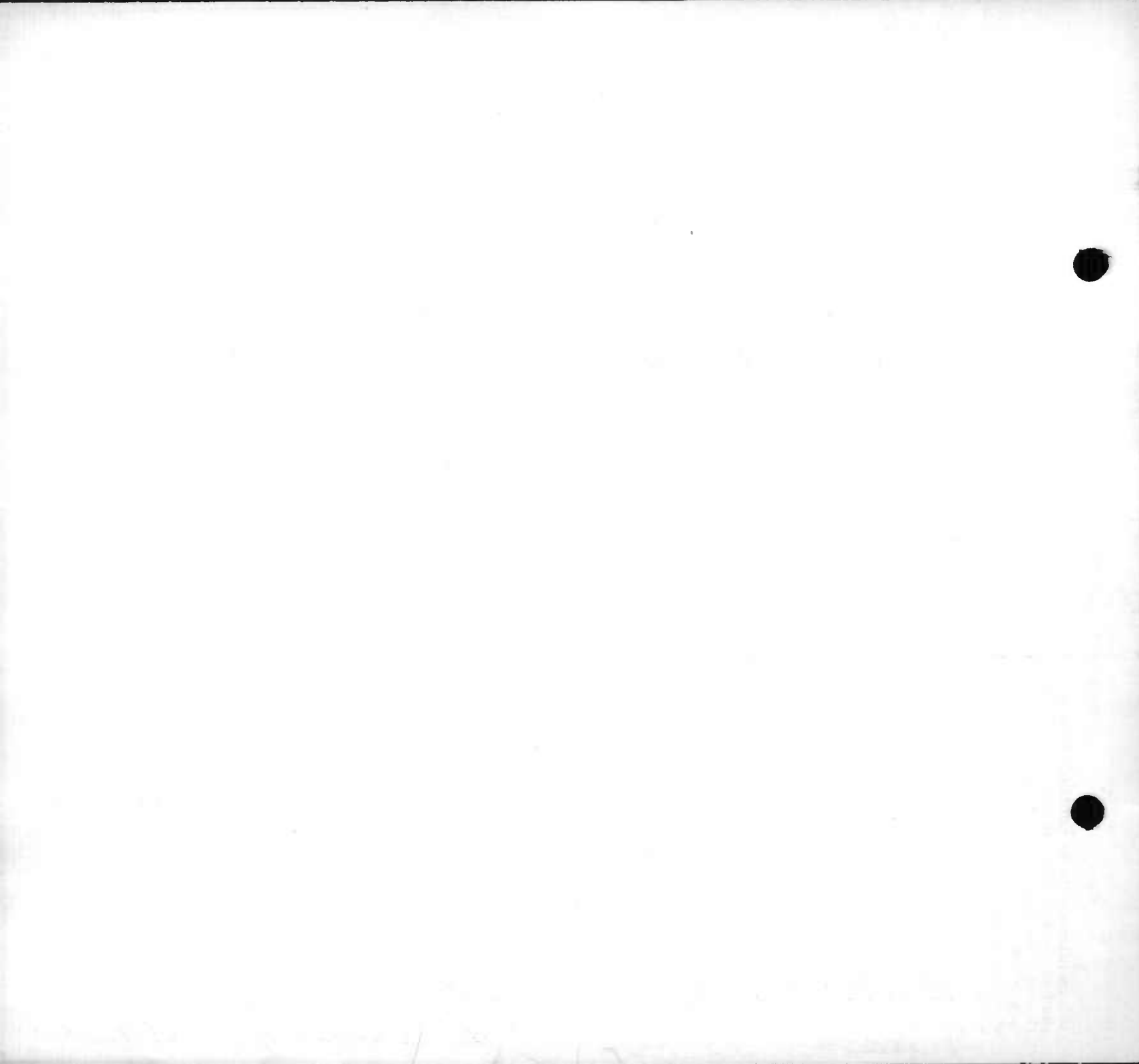
| Baltimore City Health Department | | | | REG. NO. | | 70 1973 | |
|--|---------------------|---|-------------------------------------|--|----------------------------|---|-----------------------------|
| B-650 70 1973 | | | | BIRTH NO. | | 70 1973 | |
| 1. NAME OF DECEASED
(Type or Print) <u>Brown, James E.</u> | | | | 2. DATE AND HOUR OF DEATH
<u>2/15/70</u> <u>3:10 A.M.</u> | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
<u>North Charles General Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>21211</u> <u>1348</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>North Charles General Hospital</u> | | | | C. CITY OR TOWN
<u>Baltimore</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<u>1305 Union Avenue</u> | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11/14/22</u> | 9. AGE (In years last birthday)
<u>47</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Construction Supervisor</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Cam Construction</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | 13. FATHER'S NAME
<u>Brown, James H.</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Perogy, Goldie</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>yes</u> <u>A.F.</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>220-03-8078</u> | | | | 17. INFORMANT
<u>NCGH chart</u> | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>HEPATIC FAILURE</u>
<u>HEPATIC Cirrhosis</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 YEAR</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION
<u>2/4/70</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Bleeding Esophageal Varices</u> | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-14</u> 19 <u>70</u> to <u>2-15</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>2-15</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Daniilo V. Santos M.D.</u> | | | | 23B. DATE SIGNED
<u>2/15/70</u> | | 23C. PHYSICIAN'S NAME (Type)
<u>DANILO V. SANTOS M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>2-18-70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>Garden of Faith</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Kingman Mill Rd</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 19 1970</u> | | 25B. NAME OF REGISTRAR
<u>Paul E. Gable, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Paul E. Gable, M.D.</u> | | ADDRESS
<u>3615- Chestnut Ave</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70</u> <u>1974</u> | |
|---|---------------------|---|-------------------------------------|---|---|
| L-300 70 1974 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>LIDA M. LEEDY</u> | | 2. DATE AND HOUR OF DEATH
<u>FEB. 17, 1970</u> <u>11:55</u> P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>1207</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>CHURCH HOME AND HOSPITAL</u>
<u>35</u> | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>411 W. 24TH ST (11)</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-09-14</u> | 9. AOE (In years last birthday) <u>55</u> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>VA.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>AMERICA</u> | | 13. FATHER'S NAME
<u>SAMUEL J. MAUCK</u> | | 14. MOTHER'S MAIDEN NAME
<u>MABEL BYWATERS</u> | |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>4-10-9</u> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Acute Myocardial Infarction</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Anteriosclerotic Cardiovascular Disease</u>
<u>unk.</u> | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Hours</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (u) (this hospital) attended the deceased from <u>Feb. 17</u> 19 <u>70</u> to <u>Feb. 17</u> 19 <u>70</u> that (u) (we) last saw the deceased alive on <u>Feb. 17</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Cezar A. Lopez MD</u> | | 23B. DATE SIGNED
<u>Feb. 17, 1970</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>CEZAR A. LOPEZ MD</u> | | 23D. ADDRESS
<u>CHURCH HOME AND HOSP.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| 24D. LOCATION (City, town, or county) (State) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| 25D. DATE REC'D BY HEALTH DEPT. | | 25E. NAME OF REGISTRAR | | 25F. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

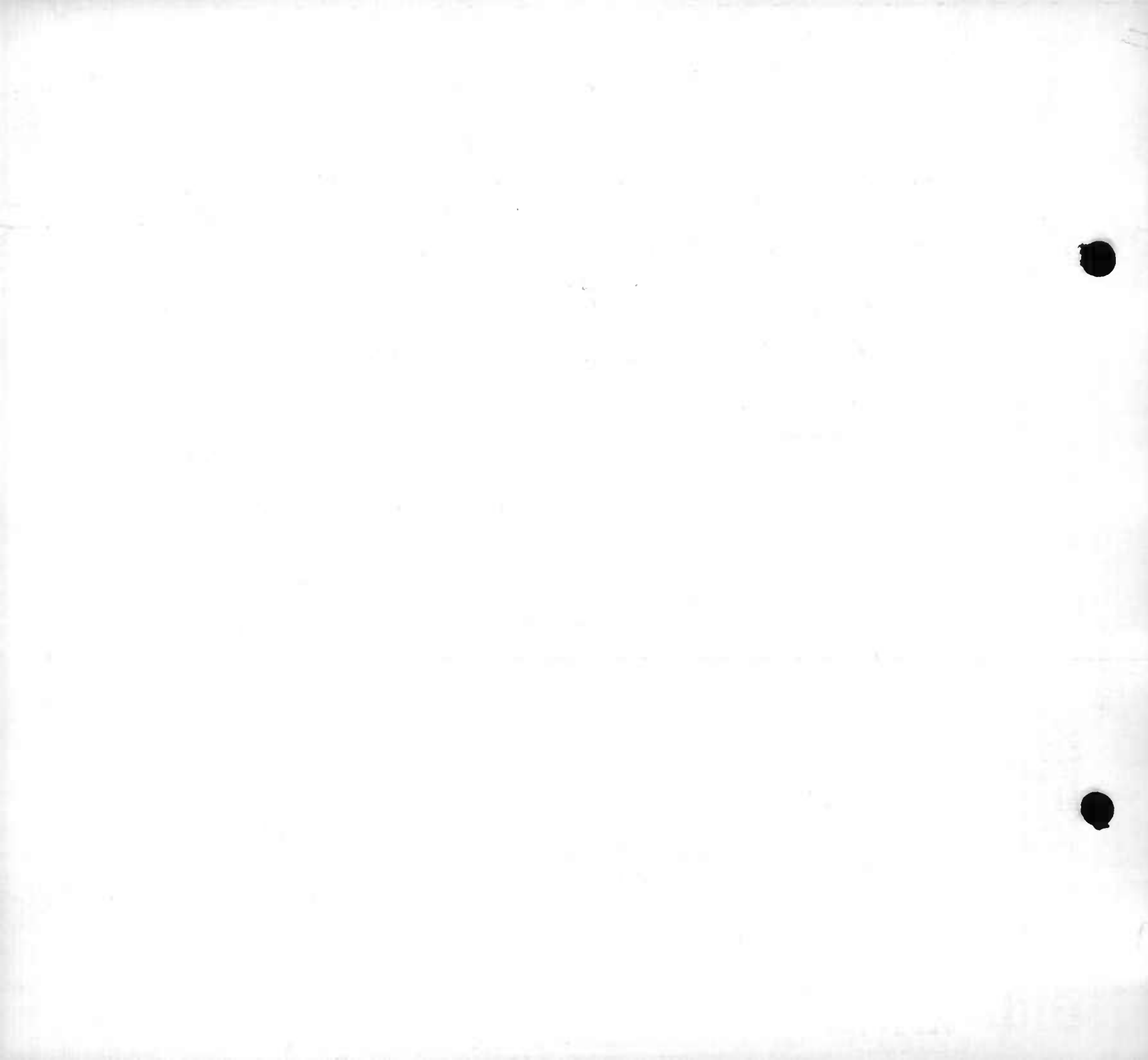
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1975</u> | |
|--|-------------------------|---|-------------------------------------|---|--|
| C-621 70 1975 | | CERTIFICATE OF DEATH | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <u>CROSBY, ELIZABETH LEIGH</u> | | 2. DATE AND HOUR OF DEATH
<u>February 17, 1970</u> <u>12.20 A.M.</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>1202</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>44 Union Memorial Hospital</u> | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
<u>BLACKSTONE APTS 601-3215 N. CHARLES</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>03/04/05</u> | 9. AGE (in years last birthday)
<u>64</u> | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOMEMAKER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>VIRGINIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>REV. PHILLIP CROSBY</u> | | 14. MOTHER'S MAIDEN NAME
<u>BLANCHE C. LEIGH</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>577-01-6428</u> | | 17. INFORMANT
<u>Mrs Margaret L. C. Spring - 403 Oak Forest Ave</u> | |
| 18. <u>14191</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<u>CAUSE OF DEATH</u> | | (A) IMMEDIATE CAUSE
<u>CARCINOMATOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>CARCINOMA OF the TONGUE</u>
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>February 14</u> 19 <u>70</u> to <u>February 17</u> 19 <u>70</u> that (I) (<u>we</u>) last saw the deceased alive on <u>February 17</u> 19 <u>70</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Miguel Karacuschansky M.D.</u> | | 23B. DATE SIGNED
<u>February 17, 1970</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>MIGUEL KARACUSCHANSKY M.D.</u> | | 23D. ADDRESS
<u>Union Memorial Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>2/19/70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Louisa PK</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>BALTO. Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 19 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR
<u>Ed. Max Nabb</u> | |
| ADDRESS
<u>301 Frederick Rd</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-620 70 1976 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1976 | |
|---|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) BURKE WALTER L | | 2. DATE AND HOUR OF DEATH
2-15-70 5:15 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE | | C. CITY OR TOWN BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNION MEMORIAL | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
44 HOSPITAL | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FIREMAN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
05-19-01 | |
| 13. FATHER'S NAME
FRANCIS BURKE | | 14. MOTHER'S MAIDEN NAME
JENNIE PORTER | | 9. AGE (In years last birthday) 68 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN | | 16. SOCIAL SECURITY NO. | | 11. BIRTHPLACE (State or foreign country)
MD | |
| 17. INFORMANT
MRS. DOROTHY BURKE | | ADDRESS
SAME | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 18. 4/2/71
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
SEVERE OBSTRUCTIVE LUNG DISEASE | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
CHRONIC BRONCHITIS +
PULMONARY HYPERTENSION
(B) DUE TO, OR AS A CONSEQUENCE OF:
CONGESTIVE HEART FAILURE
(C) ISCHEM. CORONARY VASC. DISEASE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 02-08-70 to 02-15-70
that (1) (we) last saw the deceased alive on 02-15-70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
J. A. W. 4.0 | | 23B. DATE SIGNED
02-15-70 | |
| 23C. PHYSICIAN'S NAME (Type)
J. A. MIKUS | | 23D. ADDRESS
UMH | | 23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2-18-70 | | 24C. NAME OF CEMETERY or CREMATORY
BALTIMORE NATIONAL CEMETERY | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE MD | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | 25B. NAME OF REGISTRAR
Frank J. Healy | |
| 25C. FUNERAL DIRECTOR
Frank J. Healy | | ADDRESS
814 W 36th St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------|--|--------------------------|---|----------------------------|--|-----------------------------|
| H-340 | | 70 1977 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. 70 1977 | |
| BIRTH NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Lucetta Hotteil | | | | 2-16-70 16:40 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE MD | | B. COUNTY 130.5 | |
| Key Circle Hospice | | | | C. CITY OR TOWN Balto. | | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER 3039 Keswick Rd. 21211 | | | |
| 5. SEX Female | 6. RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-29-83 | 9. AGE (in years last birthday) 86 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Credit Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Retail | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Edward M. Williams | | | | 14. MOTHER'S MAIDEN NAME Emma F. Martin | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215 01 2044 | | 17. INFORMANT Ada L. King | | ADDRESS 3039 Keswick Rd. | |
| 18. CAUSE OF DEATH | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | Coronary occlusion 6 hrs | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | | |
| ANTECEDENT CAUSES | | | | Atherosclerotic vascular disease 5 yrs | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (APPROX.) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 23 19 69 to Feb 16 19 70 that (I) (we) last saw the deceased alive on Feb 14 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Richard R. Digler | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-16-70 | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD R. DIGLER | | | | 23D. ADDRESS 1. W. Overlea Ave Balto 21206 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 19 Feb '70 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial | | 24D. LOCATION (City, town, or county) (State) Parkville, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 19 1970 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| | | | | Burgess Funeral Home | | Balto Md. | |

S-240

70

1978

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70

1978

BIRTH NO.

REG. NO.

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
Reba Siegel | | 2. DATE OF DEATH
Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>
Month Day Year Hour
2 16 70 11:00 a.m. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
3809 Boarman Ave. | | 3. DATE PRONOUNCED DEAD
Month Day Year Hour
2 16 70 11:00 a.m. | |
| 6. SEX
female | | 7. RACE
white | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH
10-14-1901 | | 10. AGE (In years lost birthday)
69 | |
| 11. BIRTHPLACE (State or foreign country)
RUSSIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 14B. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 17. SOCIAL SECURITY NO. | |
| 13. FATHER'S NAME
DAVID BROOKS | | 15. MOTHER'S MAIDEN NAME
ROSE ? | |
| 18. INFORMANT
MRS. CHARLOTTE FINEMAN | | ADDRESS
902 GLENVIEW ST.
PHILA., PA. 19111 | |
| 19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Hypertensive and arteriosclerotic cardiovascular disease
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: vascular disease
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 22D. TIME OF INJURY (Approx.) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 21. AUTOPSY? (Yes or No)
no | |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED 2/17/70 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2-18-70 | |
| 24C. NAME OF CEMETERY or CREMATORY
BETH YEHUDA ANSHE KURLAND | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1978 | | 25B. NAME OF REGISTRAR
Robert E. [Signature] | |
| 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | ADDRESS | |



11-14-1901

UNITED STATES

U.S.A.

DEPT. OF JUSTICE

OFFICE

AT NEW YORK

INVESTIGATION

405 EIGHTH ST.

NEW ORLEANS, LA. 70112

NO.

12TH MEMORANDUM FOR THE ATTORNEY GENERAL

2-18-10

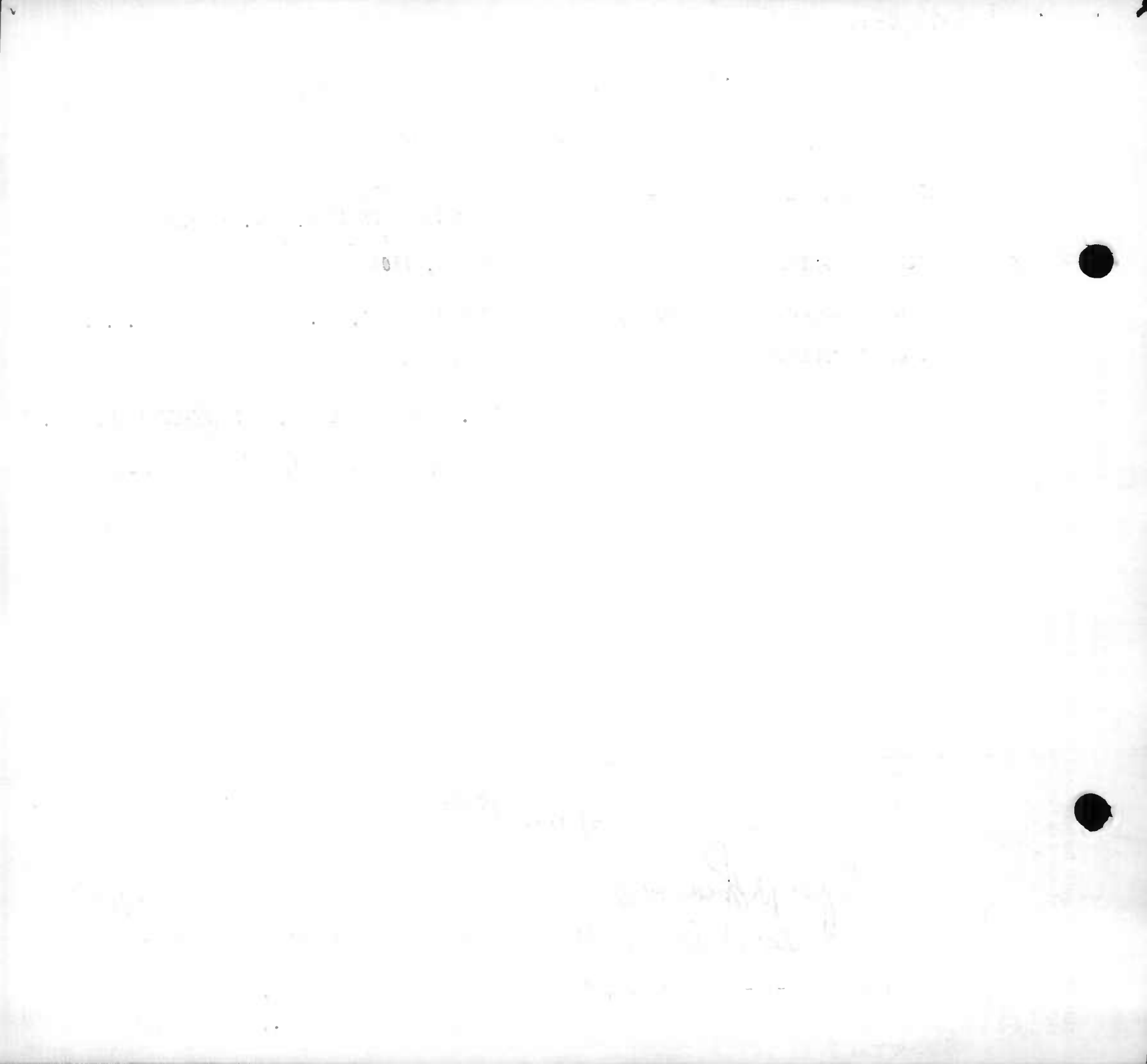
DEPT. OF JUSTICE

201 CHURCH ST. NEW ORLEANS, LA.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

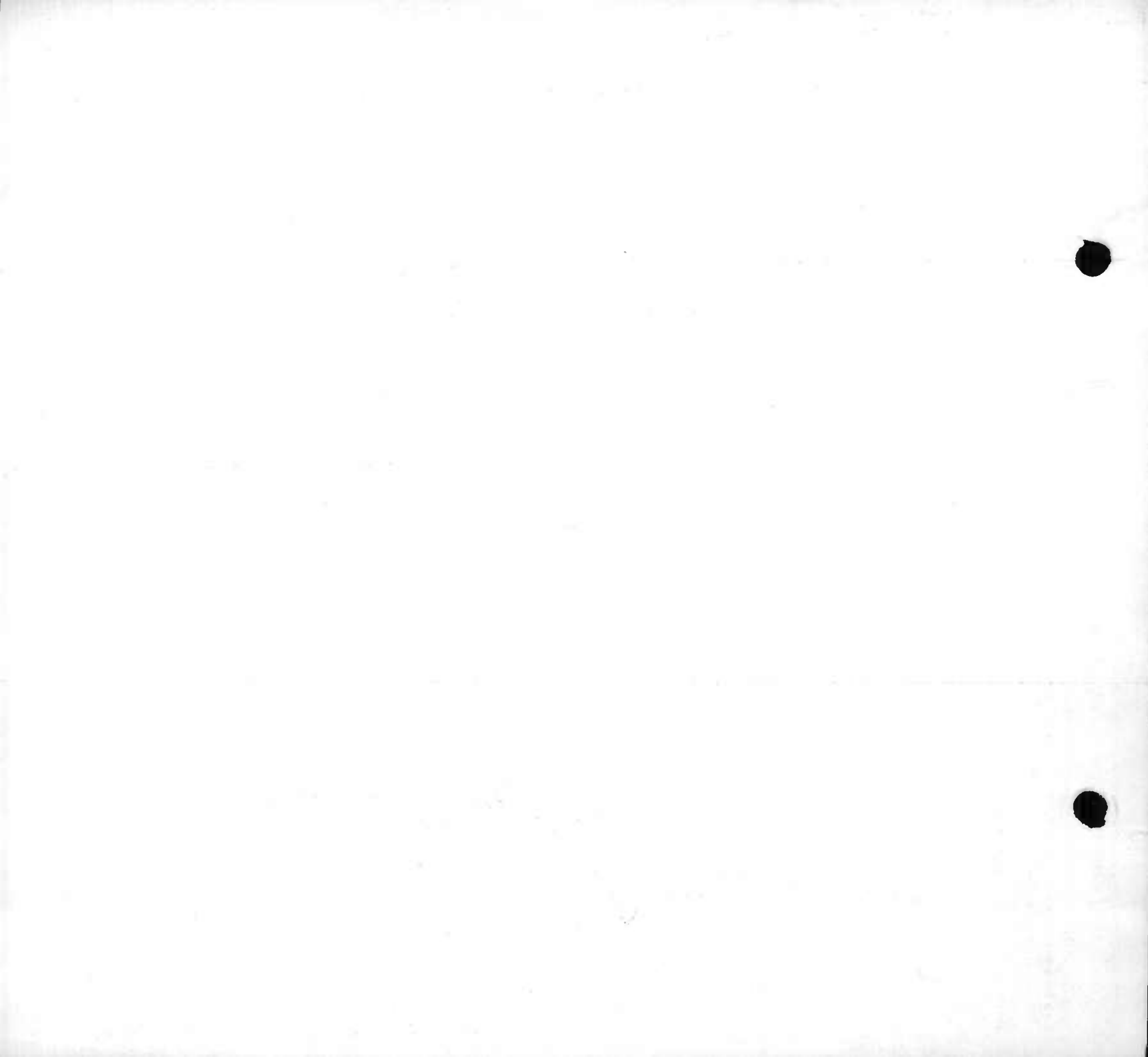
| Baltimore City Health Department | | | | 70 1979 | | REG. NO. 70 1979 | |
|--|-------------------------|---|--|--|--|--|--|
| BIRTH NO. <u>M-534</u> | | | | 70 1979 | | 70 1979 | |
| 1. NAME OF DECEASED
(Type or Print) <u>Israel M. Mendelsohn</u> | | | | 2. DATE AND HOUR OF DEATH
<u>2/17/70</u> <u>644 A</u> M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>SINAI HOSPITAL</u> | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE
<u>MARYLAND</u> | | B. COUNTY
<u>2720</u> | |
| | | | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | E. STREET AND NUMBER
<u>3614 FORDS LANE, APT. F #21215</u> | | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>1906</u>
<u>JULY 4, 1906</u> | 9. AGE (In years last birthday)
<u>63</u> | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SELF EMPLOYED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>WHOLESALE</u> | | 11. BIRTHPLACE (State or foreign country)
<u>PHILADELPHIA, PA.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>LAZER MENDELSON</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>HANNAH ?</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>MRS. ROSE MENDELSON, 3614 FORDS LANE APT. F</u> | | | |
| 18. <u>410.9 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
<u>Ant Convoy Shuntoris</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>ASCD</u>
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<u>ASCD</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>hours</u>
<u>15 yrs</u> | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1956</u> 19 to <u>2/17/70</u> 19 that (I) (we) last saw the deceased alive on <u>2/17/70</u> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Joseph Shear MD</u> | | | | 23B. DATE SIGNED
<u>2/17/70</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Joseph Shear MD</u> | | | | 23D. ADDRESS
<u>6715 Park Heights Ave</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>2-18-70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>CHIZUK AMUNO</u> | | 24D. LOCATION (City, town, or county) (State)
<u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>FEB 19 1970</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher MD</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 7-452 | | 70 1980 | | BALTIMORE CITY HEALTH DEPARTMENT | | REG. NO. | | 70 1980 | |
|---|---------------------|---|--|--|--|---|--|---|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) MARGARET FLANAGAN | | | | 2. DATE AND HOUR OF DEATH
2/17/70 3 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY 2037 | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
00
10 N. HILTON ST. BALTO. MD | | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | E. STREET AND NUMBER
10 N. HILTON ST. | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct 12, 1889 | | 9. AGE (In years last birthday)
80 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
at home | | 11. BIRTHPLACE (State or foreign country)
BALTO. MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
? BROOK S. | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Anne M. McDonald 3503 Greenvale Rd. | | | |
| 18. 410.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
Myocardial Infarction
ACVD
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 minutes | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 1, 1950 to February 17, 1970 that (I) (we) last saw the deceased alive on February 1, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Morris W Steinberg MD | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
2/18/70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
MORRIS W STEINBERG | | | | 23D. ADDRESS
3913 Hollins Ferry Rd. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2/20/70 | | 24C. NAME OF CEMETERY OR CREMATORY
Trinity Cathedral | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | 25B. NAME OF REGISTRAR
Robert E. Jones | | 25C. FUNERAL DIRECTOR
John J. Conway & Son, Inc. | | ADDRESS
901 Hollins St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1981 | |
|--|--|---|--|--|---|
| <div style="font-size: 1.5em; font-weight: bold;">L-341</div> <div style="font-size: 1.5em; font-weight: bold;">70 1981</div> | | <div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div> | | | |
| 1. NAME OF DECEASED
(Type or Print)
<div style="font-size: 1.2em; font-weight: bold;">William B. Littlepage</div> | | | 2. DATE AND HOUR OF DEATH
<div style="font-size: 1.2em; font-weight: bold;">Feb. 17, 1970</div> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<div style="font-size: 1.2em; font-weight: bold;">3705 GWYNN OAK AVENUE</div> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <div style="font-size: 1.2em; font-weight: bold;">MARYLAND</div> B. COUNTY <div style="font-size: 1.2em; font-weight: bold;">BALTIMORE</div>
C. CITY OR TOWN <div style="font-size: 1.2em; font-weight: bold;">BALTIMORE</div> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <div style="font-size: 1.2em; font-weight: bold;">3705 GWYNN OAK AVENUE 21207</div> | | |
| 5. SEX
<div style="font-size: 1.2em; font-weight: bold;">MALE</div> | 6. RACE
<div style="font-size: 1.2em; font-weight: bold;">WHITE</div> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<div style="font-size: 1.2em; font-weight: bold;">2-22-1910</div> | 9. AGE (In years last birthday)
<div style="font-size: 1.2em; font-weight: bold;">59</div> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<div style="font-size: 1.2em; font-weight: bold;">Vice President - Furniture Business</div> | | | 11. BIRTHPLACE (State or foreign country)
<div style="font-size: 1.2em; font-weight: bold;">BALTO, MD</div> | | 12. CITIZEN OF WHAT COUNTRY?
<div style="font-size: 1.2em; font-weight: bold;">USA</div> |
| 13. FATHER'S NAME
<div style="font-size: 1.2em; font-weight: bold;">William T. Littlepage</div> | | | 14. MOTHER'S MAIDEN NAME
<div style="font-size: 1.2em; font-weight: bold;">Susie Boughton</div> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<div style="font-size: 1.2em; font-weight: bold;">Yes WW 11 Army</div> | | | 16. SOCIAL SECURITY NO.
<div style="font-size: 1.2em; font-weight: bold;">216-09-7022</div> | | |
| 17. INFORMANT
<div style="font-size: 1.2em; font-weight: bold;">Caroline C. Littlepage</div> | | | ADDRESS
<div style="font-size: 1.2em; font-weight: bold;">-3705 Gwynn Oak Ave</div> | | |
| 18. <div style="font-size: 1.5em; font-weight: bold;">185X I</div>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<div style="font-size: 1.2em; font-weight: bold;">CAUSE OF DEATH</div> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<div style="font-size: 1.2em; font-weight: bold;">5 years</div> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
 | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<div style="font-size: 1.2em; font-weight: bold;">Carcinoma of Prostate with Metastases</div>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<div style="font-size: 1.2em; font-weight: bold;">D</div> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <div style="font-size: 1.2em; font-weight: bold;">2-17</div> 19 <div style="font-size: 1.2em; font-weight: bold;">70</div> to <div style="font-size: 1.2em; font-weight: bold;">2-17</div> 19 <div style="font-size: 1.2em; font-weight: bold;">76</div> , that (I) (we) last saw the deceased alive on <div style="font-size: 1.2em; font-weight: bold;">Never</div> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 23A. SIGNATURE
<div style="font-size: 1.5em; font-weight: bold;">Philip D. Lynn, M.D.</div> | | | 23B. DATE SIGNED
<div style="font-size: 1.2em; font-weight: bold;">2-17-70</div> | | 23C. PHYSICIAN'S NAME (Type)
<div style="font-size: 1.2em; font-weight: bold;">Philip D. Lynn, M.D.</div> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<div style="font-size: 1.2em; font-weight: bold;">Burial</div> | | | 24B. DATE
<div style="font-size: 1.2em; font-weight: bold;">2-19-70</div> | | 24C. NAME OF CEMETERY or CREMATORY
<div style="font-size: 1.2em; font-weight: bold;">Loudon Park Cemetery</div> |
| 25A. DATE REC'D BY HEALTH DEPT.
<div style="font-size: 1.2em; font-weight: bold;">FEB 19 1970</div> | | | 25B. NAME OF REGISTRAR
<div style="font-size: 1.2em; font-weight: bold;">Robert E. Tabery, M.D.</div> | | 25C. FUNERAL DIRECTOR
<div style="font-size: 1.2em; font-weight: bold;">Armacost Funeral Chapel-4600 Liberty Hts</div> |
| 24D. LOCATION (City, town, or county) (State)
<div style="font-size: 1.2em; font-weight: bold;">Baltimore, Maryland</div> | | | 25D. ADDRESS
<div style="font-size: 1.2em; font-weight: bold;">15 E. Chase St. Baltimore, Md.</div> | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | | | REG. NO. <u>70</u> <u>1982</u> | |
|---|--|---|--|---|--|
| S-516 70 1982 | | BIRTH NO. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| SCHAMBERG, NELLIE B. | | FEBRUARY 15, 1970 3:30P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

ST AGNES HOSPITAL
40 WILKENS & CATON AVES.
BALTIMORE, MARYLAND 21229 | | A. STATE
MD. | | B. COUNTY | |
| | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX
FEMALE | | 6. RACE
WHITE | | 7. AGE (in years last birthday)
73 | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. DATE OF BIRTH
11 06 96 | | 10. UNDER 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Linker | | 10B. KIND OF BUSINESS OR INDUSTRY
Meat Packing Co. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
HARRY MARSH | | 14. MOTHER'S MAIDEN NAME
BESSIE OREM | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
216 10 7814 | | 17. INFORMANT
BALTIMORE, MD. 21229
ST AGNES RECORDS WILKENS & CATON AVES. | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Heart failure</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Cancer of rectum</i>
DUE TO, OR AS A CONSEQUENCE OF: | | | |
| (C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 13, 19 70 to FEBRUARY 15, 19 70 that (X) (we) last saw the deceased alive on FEBRUARY 15, 19 70 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (XXXXX) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Richard P. Buyalos</i> | | 23B. DATE SIGNED
15 Feb 70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
RICHARD P. BUYALOS, MD. | | 23D. ADDRESS
BALTO. MD. 21229
ST AGNES HOSPITAL WILKENS & CATON AVES. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
Feb. 19, 1970 | | 24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
G. Truman Schwab | | 25D. ADDRESS
21229
3512 Frederick Ave. Balto. Md. | | | |

Meat Packing Co.

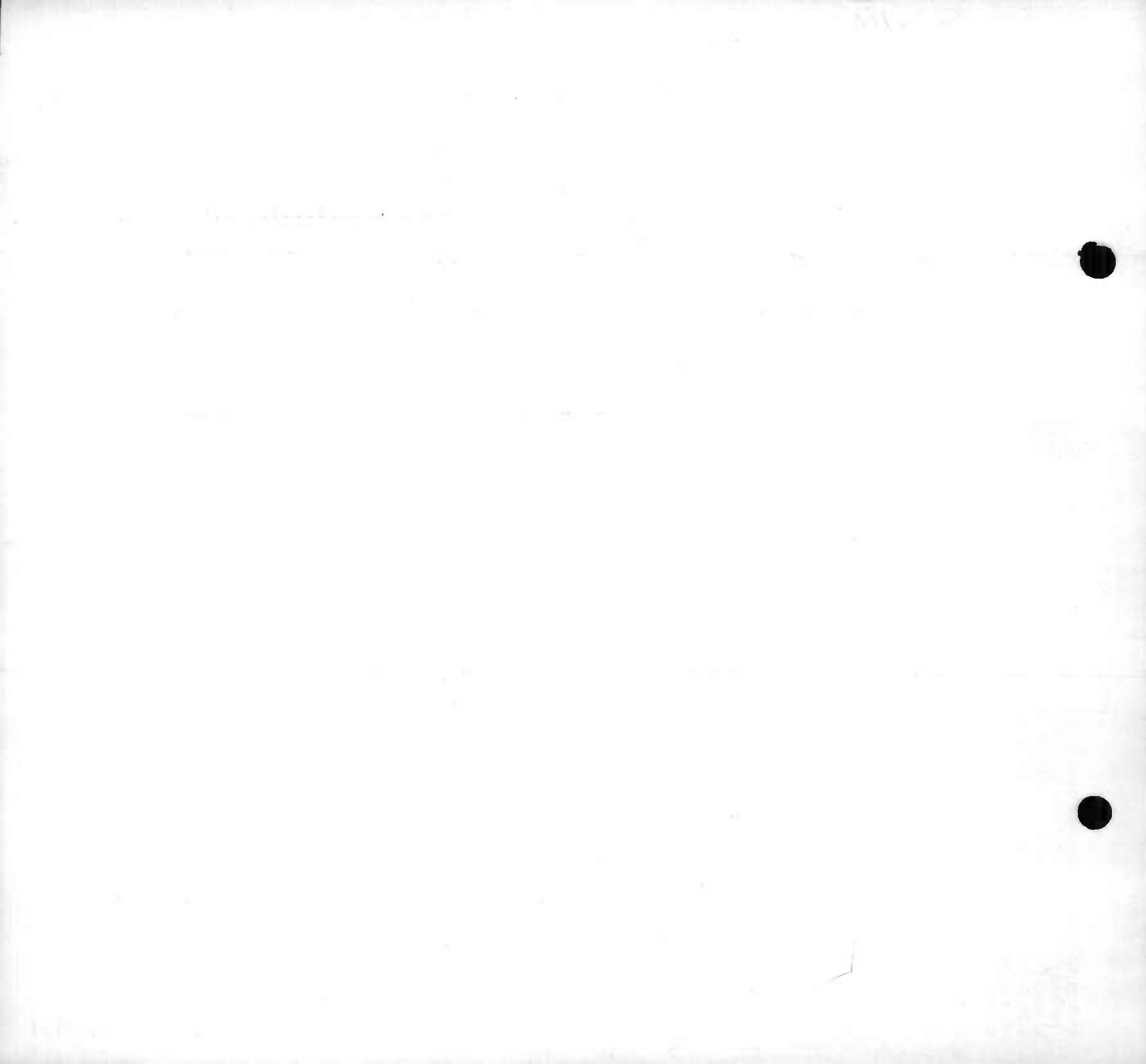
Linker



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> S-410 70 1983 BALTIMORE CITY HEALTH DEPARTMENT </div> | | <div style="display: flex; justify-content: space-between;"> 70 1983 CERTIFICATE OF DEATH REG. NO. </div> | |
| BIRTH NO. 70 1983 | | 2. DATE AND HOUR OF DEATH
2-17-70 1 7:00 A.M. | |
| 1. NAME OF DECEASED
(Type or Print) <u>Esther Salafia (ESTHER S. SALAFIA)</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u> B. COUNTY <u>1206</u> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>48 Maryland General Hospital</u> | | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | E. STREET AND NUMBER <u>2203 N. Charles St.</u> | |
| 8. DATE OF BIRTH <u>5-26-19</u> 9. AGE (In years last birthday) <u>50</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ridgewood, New Jersey</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Clerical</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Various</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>John Laughrey</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Frazier</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>200-09-5786</u> | | 17. INFORMANT <u>Samuel Salafia (husband)</u> ADDRESS <u>- same</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>PORTAL CARCINOMA</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4RS</u> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb 3, 1970</u> to <u>Feb 17, 1970</u> that (I) (we) last saw the deceased alive on <u>Feb 17, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>William L. Bodde MD</u> | | 23B. DATE SIGNED <u>2/17/70</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>William L. Bodde MD</u> | | 23D. ADDRESS <u>Maryland General Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>2/20/70</u> | |
| 24C. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMETERY</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 19 1970</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor MD</u> | |
| 25C. FUNERAL DIRECTOR <u>STEWART & MOWEN CO.</u> | | ADDRESS <u>108 W. North Av. Cityl</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| BIRTH NO. R-200 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1984 | | 70 1984 | |
| 1. NAME OF DECEASED
(Type or Print) John George Rose | | | | 2. DATE AND HOUR OF DEATH
2-13-1970 3 35 P. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
CERTIFICATE AMENDED
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House in the Pines
3-17-70 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md B. COUNTY Balto. Co. 5300 | | | |
| 5. SEX Male | | | | 6. RACE Cau. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 6-5-1884 | | 9. AGE (In years last birthday) 85 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles Rose | | 14. MOTHER'S MAIDEN NAME Johanna Neimeyer | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 214-01-4255A | | 17. INFORMANT Helen Rickenbacker | | 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Multiple Strokes
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Chronic Arteriosclerosis
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
Chronic Myocardial Infarction, Dissecting Aneurysm, Stenosis of the Aorta, Chronic Brain Syndrome | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
years
years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/10/1970 to 2/13/1970 , that (I) (we) last saw the deceased alive on 2/12/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Albert B. Bradley | | | | 23B. DATE SIGNED 2/16/70 | | 23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY, M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 2-16-1970 | | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) Parkville Balto. | | | | 24E. STATE Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 19 1970 | |
| 25B. NAME OF REGISTRAR Albert E. Taylor, M.D. | | | | 25C. FUNERAL DIRECTOR Lassahn, Funeral Home | | | |
| 25D. ADDRESS 7401 Belair Road | | | | | | | |

FUNERAL DIRECTOR: IMPORTANT

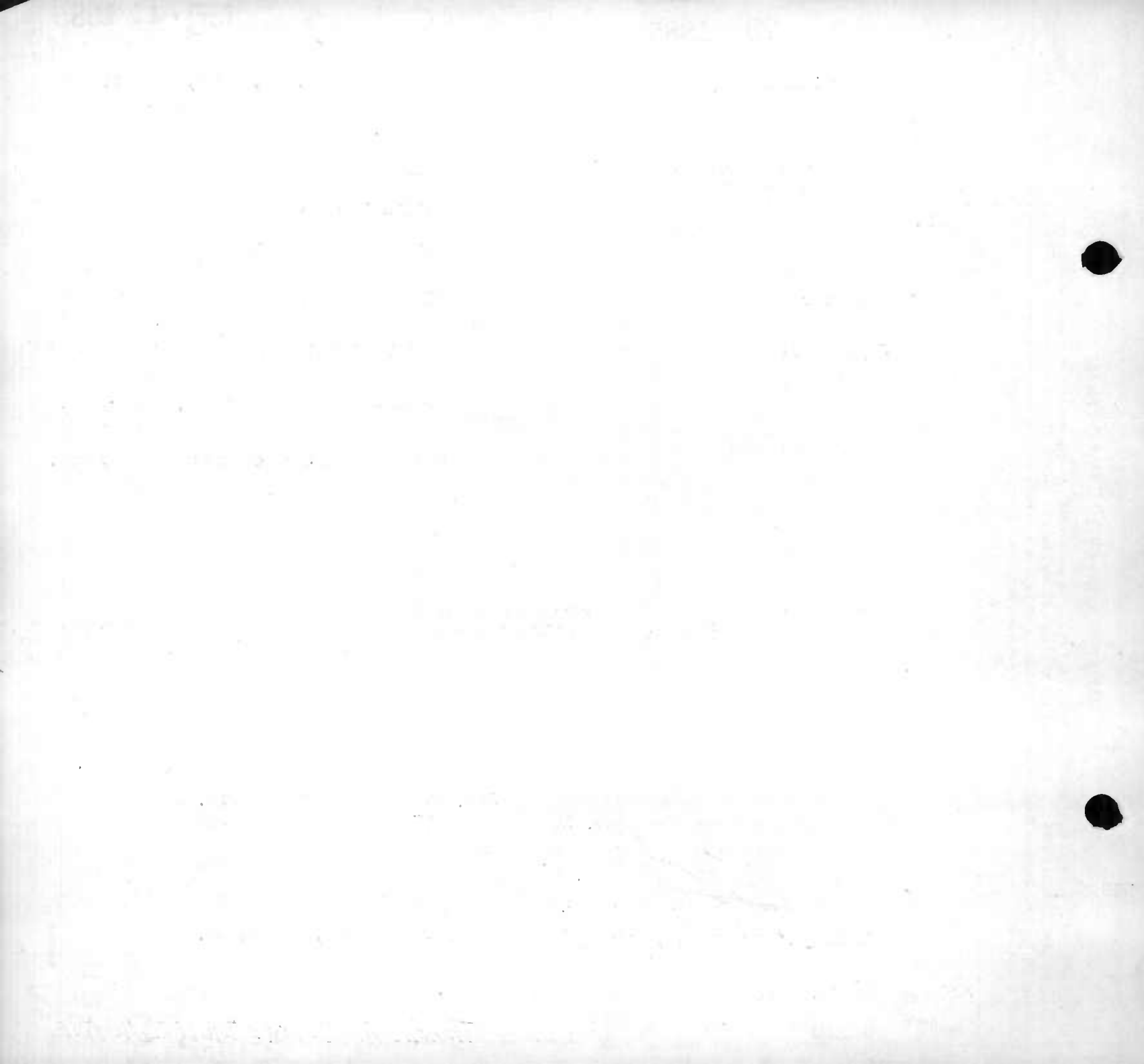
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | |
|---|---------------------|---|--|---|---|
| W-300 70 1985 | | CERTIFICATE OF DEATH | | 70 1985 | |
| 1. NAME OF DECEASED
(Type or Print) Kathleen Mary Wood | | | 2. DATE AND HOUR OF DEATH
Feb. 17, 1970, 6:30 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
US Public Health Service Hospital
3100 Wyman Parkway | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY Montgomery C. CITY OR TOWN Hillcrest D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6073- 23rd Parkway | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/12/97 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PBX operator | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
NY | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
John Magee | | |
| 14. MOTHER'S MAIDEN NAME
Mary Savage | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | |
| 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
204.02 V53.0
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute lymphocytic leukemia | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 mos. | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
Carcinoma of cecum
Diverticulosis | | | Unknown
Unknown | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 27 19 70 to Feb. 17 19 70 , that (I) (we) last saw the deceased alive on Feb. 17 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Wilhelm D. Meriwether, Surg (R) | | | | 23B. DATE SIGNED
2/18/70 | |
| 23C. PHYSICIAN'S NAME (Type)
Wilhelm D. Meriwether, Surg (R) | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREATION REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Removal for burial 2/21/70 | | 2/21/70 | | Lakeview Cem. Penn Yan, Co. N.Y. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | 25B. NAME OF REGISTRAR
John E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
THOMAS M. DEVORE 2101 FRED'K AVE. | |



| | | | | | |
|---|--|---|--|---|--|
| C-622 70 1986 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1986 | |
| BIRTH NO. 69-18975 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | |
| Sanchez Crisostomo | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> | | Month Day Year Hour | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 6. SEX | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE B. COUNTY | | male | |
| Bon Secours Hospital | | Maryland 1903 | | white | |
| 7. RACE | | C. CITY OR TOWN | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | |
| | | Baltimore | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. DATE OF BIRTH | | E. STREET AND NUMBER | | D. INSIDE CITY LIMITS? | |
| 10/10/69 | | 120 S. Fulton Ave. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years lost birthday) | | 13. FATHER'S NAME | | | |
| 4 | | Crisostomo Sanchez | | | |
| 11. BIRTHPLACE (State or foreign country) | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME | |
| Baltimore, Md. | | | | Miller | |
| 12. CITIZEN OF WHAT COUNTRY? | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| | | No | | NONE | |
| 18. INFORMANT | | 19. CAUSE OF DEATH | | ADDRESS | |
| Carol ANN Miller | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 120 S. Fulton Ave. | |
| | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dehydration secondary to gastro-enteritis | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) _____ | | | |
| | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY? (Yes or No) | |
| 2 | | | | yes | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? | |
| | | | | | |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) | | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 22F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER | | | |
| Werner U. Spitz, M.D. | | ASSOCIATE MEDICAL EXAMINER | | | |
| | | Deputy Chief Medical Examiner | | 2/17/70 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | 2/21/70 | | GLEN HAVEN PK. | |
| | | | | GLEN BURNIE, MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| FEB 19 1970 | | Robert E. Taylor, M.D. | | GEORGE L. SCHWAB | |
| | | | | ADDRESS | |
| | | | | 2101 FRED'K AVE BALD MD 21223 | |

30 1981

PHYSICAL EXAMINATION REPORT

DATE OF EXAMINATION

X

20

10.5.81

CONFIDENTIAL

NOT FOR PUBLICATION

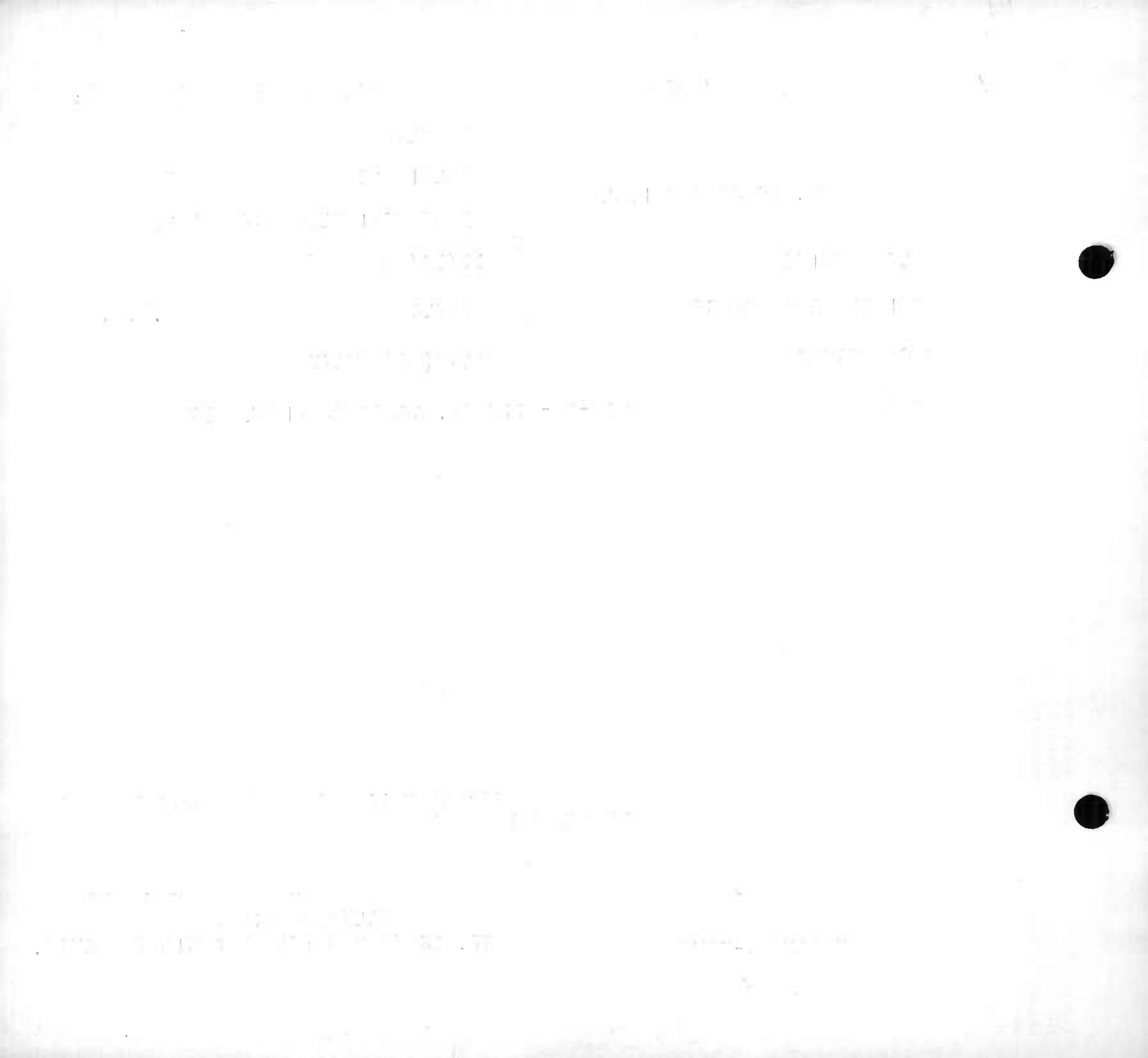
10.5.81

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70 1987</u> | |
|--|------------------|---|---|--|---|
| H-130 70 1987 | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | HAUPT, JOSEPH | | FEBRUARY 18, 1970 1:00PM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

40 ST. AGNES HOSPITAL | | | A. STATE
MARYLAND | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
3005 STRICKLAND ST 21223 | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/15/09 | 9. AGE (In years last birthday)
60 | 10. Under 1 Yr. Months Days
11 Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED PAPER HANGER | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
JACOB HAUPT | | | 14. MOTHER'S MAIDEN NAME
MARY(NEE EHATT) | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
NONE | | 16. SOCIAL SECURITY NO.
212-18-9115 | 17. INFORMANT
5 ST. AGNES HOSPITAL RECORDS | | |
| 18. <u>436.9 I</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| (A) IMMEDIATE CAUSE <u>Cardiorespiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF:
<u>Cerebrovascular accident</u> | | | | | |
| (B) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| (C) DUE TO, OR AS A CONSEQUENCE OF: | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 13 1970</u> to <u>FEBRUARY 18 1970</u> that (I) (we) last saw the deceased alive on <u>FEBRUARY 18 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>K. Zaheer-Kahn</u> | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
02 18 70 |
| 23C. PHYSICIAN'S NAME (Typo)
K. ZAHEER-KAHN | | | 23D. ADDRESS
BALTO, MD 21229
ST. AGNES HOSP; CATON & WILKENS AVES. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>2-21-70</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>London Park</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Balto Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Robert E. Fisher, M.D.</u> | |
| ADDRESS
<u>2101 Frederick Ave</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. <u>70</u> <u>1988</u> | |
|--|-----------------------------|---|--|---|---|
| BIRTH NO. <u>W-355</u> | | 70 1988 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) <u>CHRISTOPHER M. WITTMANN</u> | | | 2. DATE AND HOUR OF DEATH
<u>2-17-70</u> <u>5:15</u> P. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MD.</u> B. COUNTY <u>2003</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>BON SECOUR HOSPITAL</u> | | | C. CITY OR TOWN
<u>BALTIMORE</u> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>34</u> | | | E. STREET AND NUMBER
<u>1909 W. LOMBARO ST.</u> | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>CAUCASIAN</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>MAR-1901?</u> | 9. AGE (In years last birthday)
<u>68?</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>MACHINIST</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>B&O R.R.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | 13. FATHER'S NAME
<u>GEORGE WITTMAN</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>ROSE</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | |
| 16. SOCIAL SECURITY NO.
<u>705076436</u> | | | 17. INFORMANT
<u>ROBT. K. WITTMAN</u> | | |
| ADDRESS
<u>1235 CARROLL ST. BALTO. MD.</u> | | | 18. CAUSE OF DEATH | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>492X I</u> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Hours</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | (A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<u>VIRAL Pneumonia</u> | | |
| | | | (B) DUE TO, OR AS A CONSEQUENCE OF:
<u>Myocardial heart disease</u> <u>years</u> | | |
| | | | (C) <u>Emphysema</u> <u>years</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
<u>obstructive pulmonary disease</u>
<u>generalized arteriosclerosis</u> | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>May 1959</u> to <u>Feb. 17 1970</u> , that (I) (we) last saw the deceased alive on <u>Feb. 14 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Henry Armanas M.D.</u> | | | | 23B. DATE SIGNED
<u>Feb. 19, 1970</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>HENRY ARMANAS</u> | | | | 23D. ADDRESS
<u>1934 Wilkens Ave Balto 23, Md</u> | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
<u>BURIAL</u> | | 24B. DATE
<u>2-20-70</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>ST. PAUL'S LUTHERAN BALTO. (VIOLETVILLE) MD.</u> | |
| 24D. LOCATION (City, town, or county) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR
<u>Rebecca Taylor</u> | |
| 24G. FUNERAL DIRECTOR
<u>GEORGE L. SCHWAB INC.</u> | | 24H. ADDRESS
<u>2101 FRED'K AVE. BALTO. MD 21223</u> | | 24I. DATE
<u>FEB 19 1970</u> | |

What I remember

Heptachlor epoxide

General term
for the insecticide
which is a long-chain

to get to the

Heptachlor epoxide

Heptachlor epoxide

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1989 | |
|--|---------------------|---|---|--|---|
| <div style="display: flex; justify-content: space-between;"> G-436 70 1989 70 1989 </div> | | | | | |
| BIRTH NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Edward C. Golden Sr.</i> | | | 2. DATE AND HOUR OF DEATH
<i>February 18 1970 6A M.</i> | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>1601</i> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>908 Bennett Place Baltimore</i> | | | C. CITY OR TOWN
<i>Baltimore</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
<i>908 Bennett Place # 21223</i> | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>C</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>6-15-1922</i> | 9. AGE (In years lost birth day)
<i>87</i> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<i>Cabot Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> |
| 13. FATHER'S NAME
<i>Charles Golden</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Charlott Murray</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
<i>Madeline C. Golden</i> ADDRESS <i>Same</i> | | |
| <div style="display: flex;"> <div style="flex: 1;"> <p>18. <i>412.21</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</p> </div> <div style="flex: 1;"> <p>CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
<i>My father an acute death
Cerebral Disease</i>
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) _____</p> </div> <div style="flex: 0.5;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 yrs</i></p> </div> </div> | | | | | |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
<i>Blood in Urinary Bladder</i></p> | | | | | |
| 19A. DATE OF OPERATION
<i>0 0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>0</i> | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <i>1960</i> to <i>1970</i> that (I) (we) last saw the deceased alive on <i>7-6-16</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | |
| 23A. SIGNATURE
<i>[Signature]</i> | | | | 23B. DATE SIGNED
<i>2-19-70</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>FUNCTION</i> | | | | 23D. ADDRESS
<i>848 Haven Ave Baltimore</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2-21-70</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Arbutus Memorial Pl</i> | |
| 24D. LOCATION
<i>Arbutus Rd</i> | | 24E. DATE REC'D BY HEALTH DEPT.
<i>FEB 19 1970</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, R.D.</i> | |
| 25C. FUNERAL DIRECTOR
<i>Clayton Wilson</i> | | 25D. ADDRESS
<i>1000 E. Quantway Ave</i> | | | |

1

T-460 70 1990 BALTIMORE CITY HEALTH DEPARTMENT

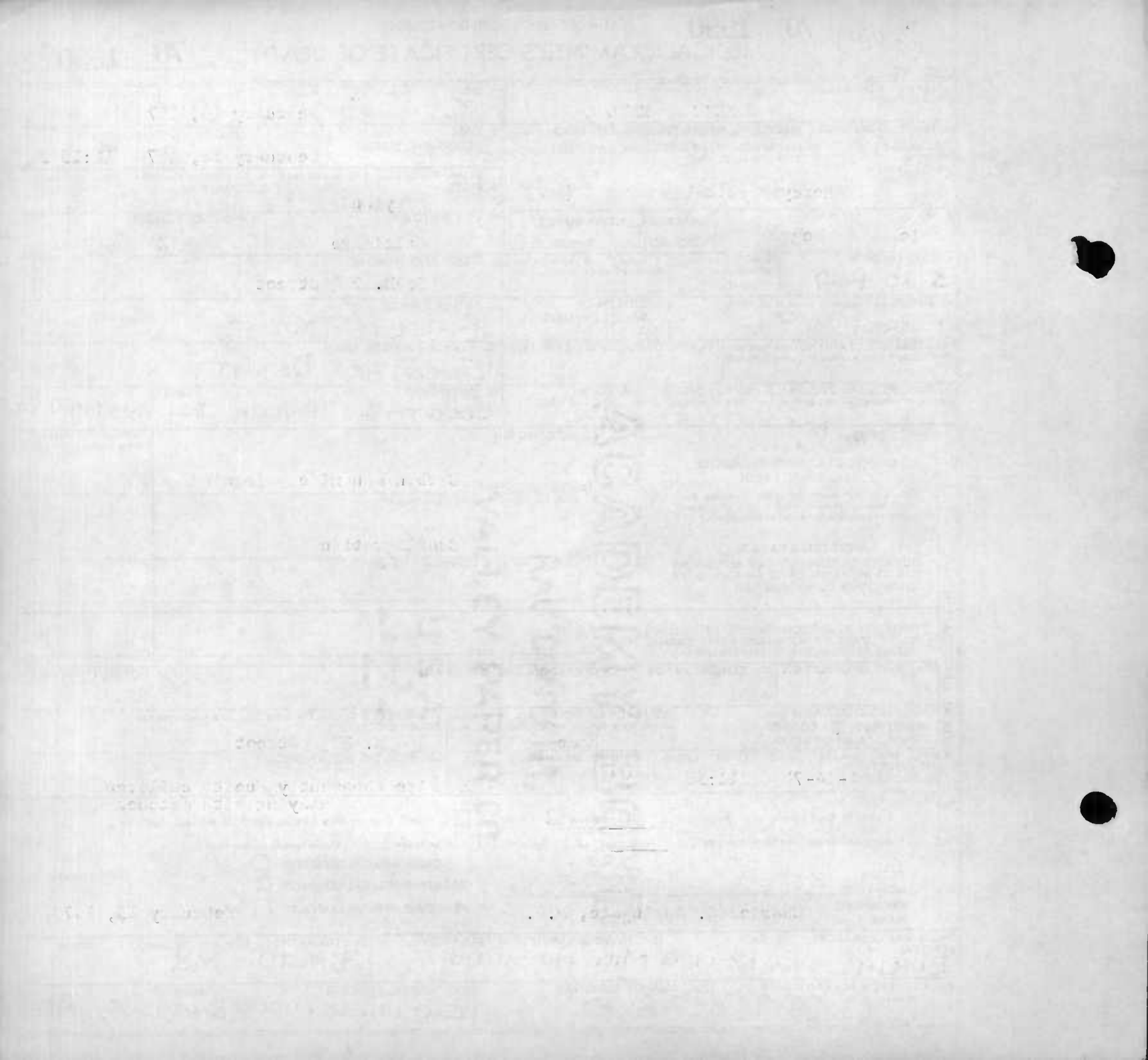
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1990

BIRTH NO.

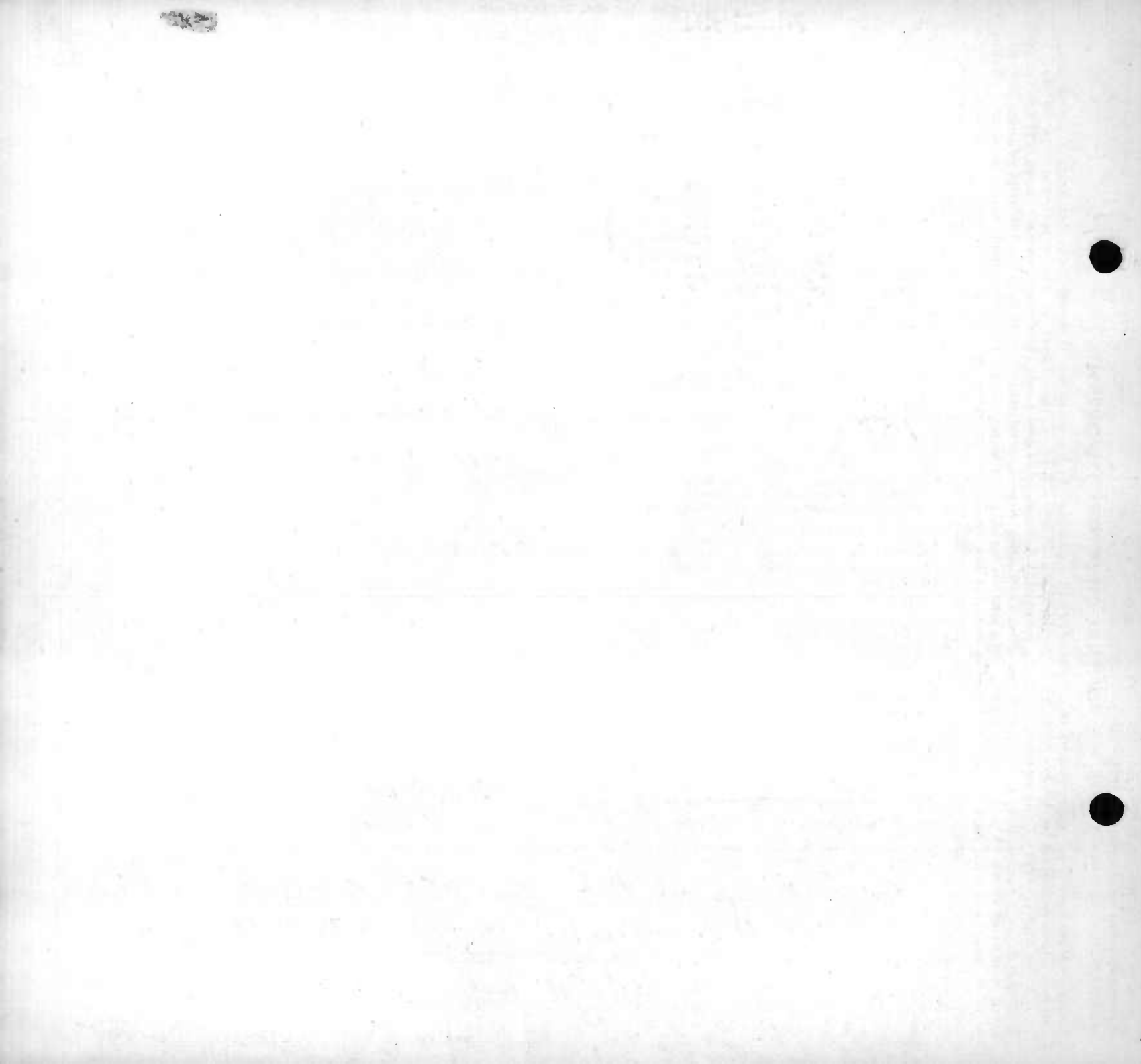
| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE OF DEATH | | 3. DATE PRONOUNCED DEAD | | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | |
| ROBERT TAYLOR | | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year | | February 14, 1970 | | (If not in hospital or institution, give street address or location) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | Hour | | Hour | | 12:15 P M. | |
| Mercy Hospital (DOA) | | | | February 14, 1970 | | | |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | A. STATE | | B. COUNTY | | 12 06 | |
| Maryland | | | | Baltimore | | | |
| 6. SEX | | 7. RACE | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | C. CITY OR TOWN | |
| Male | | Negro | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | D. INSIDE CITY LIMITS? | |
| 9. DATE OF BIRTH | | 10. AGE (In years last birthday) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 5-20-1927 | | 42 | | FLORENCE S.C. | | U.S.A. | |
| 13. FATHER'S NAME | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| ROBERT TAYLOR | | | | ELENTAR DEWITT | | 24 | |
| 17. SOCIAL SECURITY NO. | | 18. INFORMANT | | 19. CAUSE OF DEATH | | 20. DATE OF OPERATION | |
| 248-32-2813 | | ELENTAR TAYLOR | | Carbon monoxide poisoning | | 2-18-1970 | |
| ADDRESS | | 821 HILLMAN CT. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | 21. AUTOPSY? (Yes or No) | |
| | | | | (B) Conflagration DUE TO, OR AS A CONSEQUENCE OF: | | No | |
| | | | | (C) | | | |
| 22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 23. ANTECEDENT CAUSES | | 24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | 25. DATE OF OPERATION | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | 2-18-1970 | |
| | | | | | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | | | 27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | | | | | | home | |
| | | | | | | 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | | 304 E. 20 1/2 Street | |
| | | | | | | 29. HOW DID INJURY OCCUR? | |
| | | | | | | Fire apparently due to children playing with matches | |
| | | | | | | 30. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| | | | | | | 31. ACTUAL SIGNATURE | |
| | | | | | | Charles S. Springate, M.D. | |
| | | | | | | 32. DATE SIGNED | |
| | | | | | | February 15, 1970 | |
| 33. BURIAL CREMATION, REMOVAL (Specify) | | 34. DATE | | 35. NAME OF CEMETERY or CREMATORY | | 36. LOCATION (City, town, or county) (State) | |
| BURIAL | | 2-18-1970 | | MT. AUBURN | | BALTO. Md. | |
| 37. DATE REC'D BY HEALTH DEPT. | | 38. NAME OF REGISTRAR | | 39. FUNERAL DIRECTOR | | 40. ADDRESS | |
| FEB 19 1970 | | Robert E. Johnson | | E.O WILSON | | 1000 BRANTLEY AVE | |

VS 151-REV. 7/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 | | 1992 | |
|--|--|--|--|---|---|--|--|
| BIRTH NO.
1. NAME OF DECEASED
(Type or Print) JOSEPH LAWRENCE DOYLE | | 2. DATE AND HOUR OF DEATH
2-15-70 | | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
JOHNS HOPKINS HOSPITAL
33 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 702
C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2606 McELDERRY ST. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-1-1891 | 9. AGE (In years lost birthday)
78 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PLUMBER | | 10B. KIND OF BUSINESS OR INDUSTRY
PLUMBING | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GERALD P. DOYLE | | | | 14. MOTHER'S MAIDEN NAME
MARY ANN CREAGER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
21318 0205 | | 17. INFORMANT
Mrs. Mary E. Doyle | | ADDRESS
2606 Mc Elderry St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
CARCINOMATOSIS
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) CARCINOMA- URINARY BLADDER | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs.
2 yrs | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | | | |
| 19A. DATE OF OPERATION
0 1969 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
GENITO-URINARY | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from OCTOBER 1967 to 2-13-70 19
that (I) (we) last saw the deceased alive on 2/13/70 19 and that (in my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Benj. B. Moses, M.D. | | | | 23B. DATE SIGNED
2/17/70 | | | |
| 23C. PHYSICIAN'S NAME (Type)
BENJ. B. MOSES, M.D. | | 23D. ADDRESS
448 N. LUZERNE AVE. BALTO. MD | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2-18-70 | | 24C. NAME OF CEMETERY or CREMATORY
GARDENS OF FAITH Cem. | | 24D. LOCATION (City, town, or county) (State)
BALTO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR
Gardner Miller | | ADDRESS
-2334 Jefferson St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. | 70 1993 |
|---|---------------------|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> M-614 70 1993 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) PAULINE MARVEL | | 2. DATE AND HOUR OF DEATH
2-17-70 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

JOHNS HOPKINS HOSPITAL
33 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY 702 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN
BALTIMORE | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | E. STREET AND NUMBER
2700 JEFFERSON ST. | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-1-1891 | 9. AGE (In years last birthday)
78 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WAITRESS | | 10B. KIND OF BUSINESS OR INDUSTRY
TAVERN | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
SLAKE | | 14. MOTHER'S MAIDEN NAME
AUGUSTA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214 12 4363 | | 17. INFORMANT
Mr. Harry H. Marvel - 2700 Jefferson St. | |
| 18. 412.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

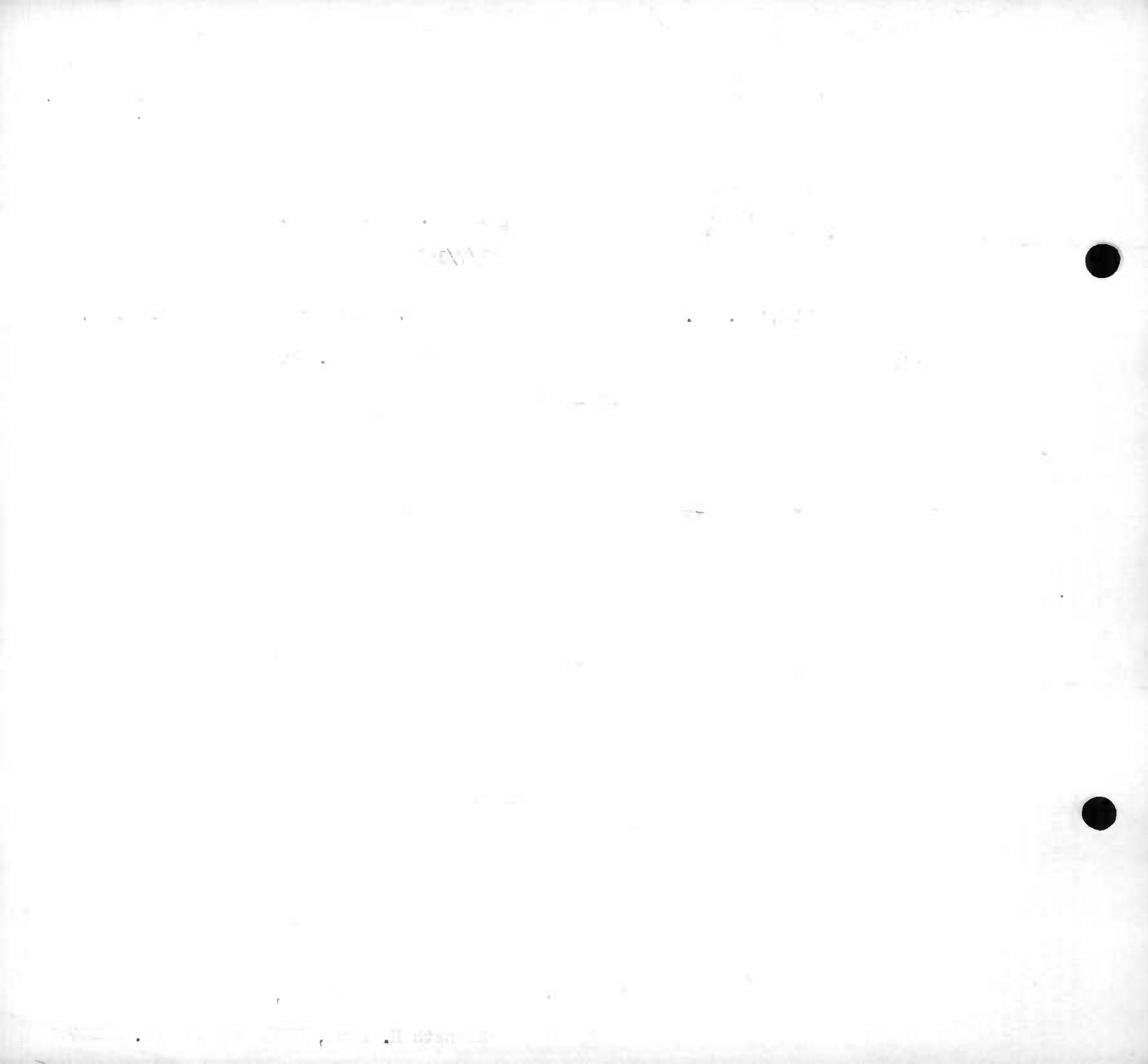
ARTERIOSCLEROTIC HEART DISEASE | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 years | |
| ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
DISEASE | | | |
| | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1951 19 to 2/17/70 19, that (I) (we) last saw the deceased alive on 2/14/70 19 and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Max Baum | | | | 23B. DATE SIGNED
2/19/70 | |
| 23C. PHYSICIAN'S NAME (Type)
MAX BAUM, M.D. | | | | 23D. ADDRESS
7422 EASTERN AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
2-20-70 | | 24C. NAME OF CEMETERY or CREMATORY
PARKWOOD CEM. | |
| | | | | 24D. LOCATION (City, town, or county) (State)
BALTO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | 25B. NAME OF REGISTRAR
Robert E. Gaskins | | 25C. FUNERAL DIRECTOR
Shantley Miller - 2334 Jefferson St. | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| G-620 70 1994 | | BALTIMORE CITY HEALTH DEPARTMENT | | 70 1994 | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. NAME OF DECEASED
(Type or Print)
Grice, Jones, Mary | | | 2. DATE AND HOUR OF DEATH
2-17-70 12:10 A. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

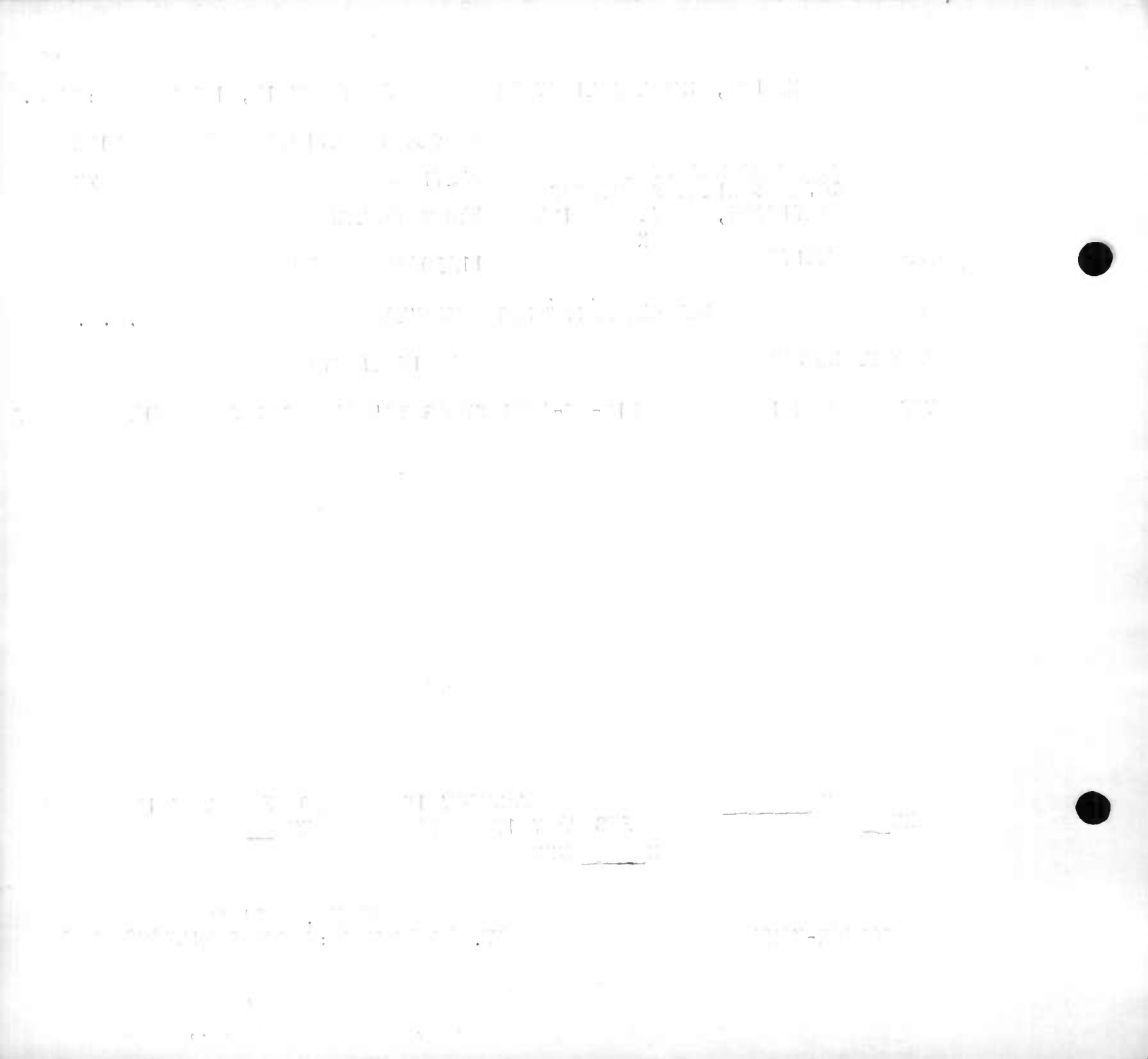
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
39 Provident Hospital
1514 Divison Street
Baltimore, Maryland 21217 | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 1603
C. CITY OR TOWN Baltimore,
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1123 N. Fulton Ave. | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/7/1917 | 9. AGE (In years last birthday)
52 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cat&Paw Holtite, mfg. Co. | | | 11. BIRTHPLACE (State or foreign country)
South Carolina | | |
| 13. FATHER'S NAME
John Jones | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
218-10-5725 | | |
| 17. INFORMANT
John Grice-Husband | | | ADDRESS
Same | | |
| 18. 230.91
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) IMMEDIATE CAUSE Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF:
(B) Diabetes Mellitus
DUE TO, OR AS A CONSEQUENCE OF:
(C) _____
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
19A. DATE OF OPERATION
1-20-70
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
No
20A. AUTOPSY? (Yes or No)
No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)
21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-20-70 19 to 2-17-70 19
that (I) (we) last saw the deceased alive on 2-17-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Raymundo R. Corpaz, M.D.
23C. PHYSICIAN'S NAME (Type)
Raymundo R. Corpaz, M.D. | | | 23B. DATE SIGNED
Feb. 17, 1970 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
2/21/70 | | |
| 24C. NAME of CEMETERY or CREMATORY
Arbutus Mem. Park | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | | 25B. NAME of REGISTRAR
JAMES E. [unclear] | | |
| 25C. FUNERAL DIRECTOR
Kenneth H. Law | | | ADDRESS
3503 Berwyn Ave. 21207 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1995 | |
|--|---------|--|------------------|--|-----------------------------|
| C-620 70 1995 | | BALTIMORE CITY HEALTH DEPARTMENT | | | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | REG. NO. 70 1995 | |
| 1. NAME OF DECEASED
(Type or Print) | | CHAIRS, CHARLES LINSTEAD | | 2. DATE AND HOUR OF DEATH
FEBRUARY 17, 1970 9:55 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
40 | | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | MARYLAND BALTIMORE 5300 21228 | |
| ST AGNES HOSPITAL
CATON & WILKENS AVENUES
BALTIMORE, MARYLAND 21229 | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| | | BALTIMORE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| E. STREET AND NUMBER | | 440 GREENLOW ROAD | | | |
| 5. SEX | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | 10. Under 1 Yr. Months Days |
| MALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11/30/99 | 70 | 11. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | Gas & Elec. Co.
GAS MANUFACTURING | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| SAMUEL CHAIRS | | ANNIE LINSTEAD | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES W W 1 | | 212-05-4673 | | ST AGNES RECORDS CATON & WILKENS AVES | |
| 18. 599.9 I | | CAUSE OF DEATH | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) IMMEDIATE CAUSE | | Respiratory Failure | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | DUE TO, OR AS A CONSEQUENCE OF: | | Acute Pulm. edema. | |
| ANTECEDENT CAUSES | | (B) | | Uric Acid Obstructive Nephropathy | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO, OR AS A CONSEQUENCE OF: | | C. Uraemia | |
| (C) | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (X) (this hospital) attended the deceased from JANUARY 15 19 70 to FEBRUARY 17 19 70 that (X) (we) last saw the deceased alive on FEBRUARY 17 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Zaheer-Kahn | | 02/18/70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| ZAHEER-KAHN | | BALTO, MD 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 2/20/70 | | Cedar Hill Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| FEB 19 1970 | | Robert E. Sabin | | Witzke, 1630 Edmondson Ave., 21228 | |



| BIRTH NO. | | REG. NO. | |
|---|--|--|--|
| B-400 | | 70 1996 | |
| BALTIMORE CITY HEALTH DEPARTMENT | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Washington</u>
<u>GEORGE BELL</u> | | 2. DATE OF DEATH
Known <input type="checkbox"/> Month Day Year Hour
Estimated <input type="checkbox"/> M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
<u>00</u> 1525 N. Payson Street | | 3. DATE PRONOUNCED DEAD <u>February 17, 1970</u> Month Day Year Hour
6:50 P. M. | |
| 6. SEX
Male | | 7. RACE
Negro | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Baltimore | |
| 9. DATE OF BIRTH | | D. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 10. AGE (In years last birthday) <u>62</u> | | E. STREET AND NUMBER
1525 N. Payson Street | |
| 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U S A</u> | |
| 13. FATHER'S NAME
? | | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | |
| 15. MOTHER'S MAIDEN NAME
? | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 17. SOCIAL SECURITY NO.
<u>212-07-7477</u> | | 18. INFORMANT
Mrs Julia Miller, same | |
| 19. <u>162.1</u>
CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 20A. DATE OF OPERATION | | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21. AUTOPSY? (Yes or No)
no | | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? | |
| 22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22F. HOW DID INJURY OCCUR? | | 23. | |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>Ronald N. Kornblum</u>
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED
2/18/70 | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | |
| 24B. DATE
2/21/70 | | 24C. NAME OF CEMETERY OR CREMATORY
MT Auburn Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | |
| 25B. NAME OF REGISTRAR
<u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR
Adolphus Halstead 1206 W North A | |

ACADEMY & BOND

WALLEY & FISH CO

70 1997 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 1997

BIRTH NO.

| | | | | | |
|--|-------------------------|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) CRISTINA CHRISTINE COOPER | | | | 2. DATE OF DEATH
Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 2 Day 13 Year 70 Hour 1:31 a M. | |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
6021 Greenspring Ave. | | | | 3. DATE PRONOUNCED DEAD
Month February Day 13 Year 1970 Hour 1:31 a M. | |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 2740 | | | | | |
| 6. SEX
Female | 7. RACE
Negro | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | C. CITY OR TOWN
Balto. | |
| 9. DATE OF BIRTH
7-19-39 | | 10. AGE (In years lost birthday) 30 | | E. STREET AND NUMBER
6021 Greenspring Ave. | |
| 11. BIRTHPLACE (State or foreign country)
Pueblo, Mexico | | 12. CITIZEN OF
U.S.A. | | 13. FATHER'S NAME
Unk. | |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 14B. KIND OF BUSINESS OR INDUSTRY
Home | | 15. MOTHER'S MAIDEN NAME
Unk. | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 17. SOCIAL SECURITY NO. | | 18. INFORMANT
Mrs. Shirley Cooper | |
| | | | | ADDRESS
4107 Roland View Avenue | |
| 19. E966X1 CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21. AUTOPSY? (Yes or No)
yes | | | | | |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
Home | | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
6021 Greenspring Ave. | |
| 22D. TIME OF INJURY (APPROX.)
Month 2 Day 13 Year 70 ? m. | | 22E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 22F. HOW DID INJURY OCCUR?
Subject found stabbed to death | |
| 23.
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D.
EXAMINER'S NAME (Type)
DATE SIGNED 2/13/70 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
2-18-70 | | 24C. NAME OF CEMETERY OR CREMATORY
Balto. Nat'l Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | 25B. NAME OF REGISTRAR
Robert E. Fisher, R.D. | | 25C. FUNERAL DIRECTOR
MORTON & DYETT F.H. | |
| | | | | ADDRESS
1701 Laurens Street | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REG. NO. 70 1998 | |
|---|--------------|---|---|--|---|
| 70 1998 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | 1. NAME OF DECEASED
(Type, or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Montgomery Virginia (Vergie) | | 2-14-70 9:15 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Duke Land Nursing Home
90 1501 Duke Land St. | | | A. STATE & COUNTY
Maryland 1402 | | |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION | | | C. CITY OR TOWN
Baltimore | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| | | | E. STREET AND NUMBER
Luch Raven VA Hospital | | |
| 5. SEX
m | 6. RACE
C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-23-97 | 9. AGE (in years last birthday)
72 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
factory | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Charlotte, N.C. | |
| 13. FATHER'S NAME
James R. Montgomery | | 14. MOTHER'S MAIDEN NAME
Mary Moore | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes 7/29/18 12/13/18 | | 16. SOCIAL SECURITY NO.
217-024573 | | 17. INFORMANT ADDRESS
Duke Land 1501 Duke Land St. | |
| 18. I 199.0 I CAUSE OF DEATH | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Ante static Carcinoma | | | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO, OR AS A CONSEQUENCE OF: | | |
| | | | (C) DUE TO, OR AS A CONSEQUENCE OF: | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 1 Month (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-2-1970 to 2-14-1970 that (I) (we) last saw the deceased alive on 2-14-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Forcival C. Smith | | | | 23B. DATE SIGNED
2-17-70 | |
| 23C. PHYSICIAN'S NAME (Type)
DEGREE | | | | 23D. ADDRESS
1501 Duke Land Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 2/20/70 | | Balto. Nat'l Cem. | |
| 24D. LOCATION | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR | |
| Baltimore, Maryland | | Robert E. Taber | | Horstman & Dyett F.H. 1701 Laurens | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 19 1970 | | | | | |

Hospital gave last address as
1552 Argyle Ave.

B-630

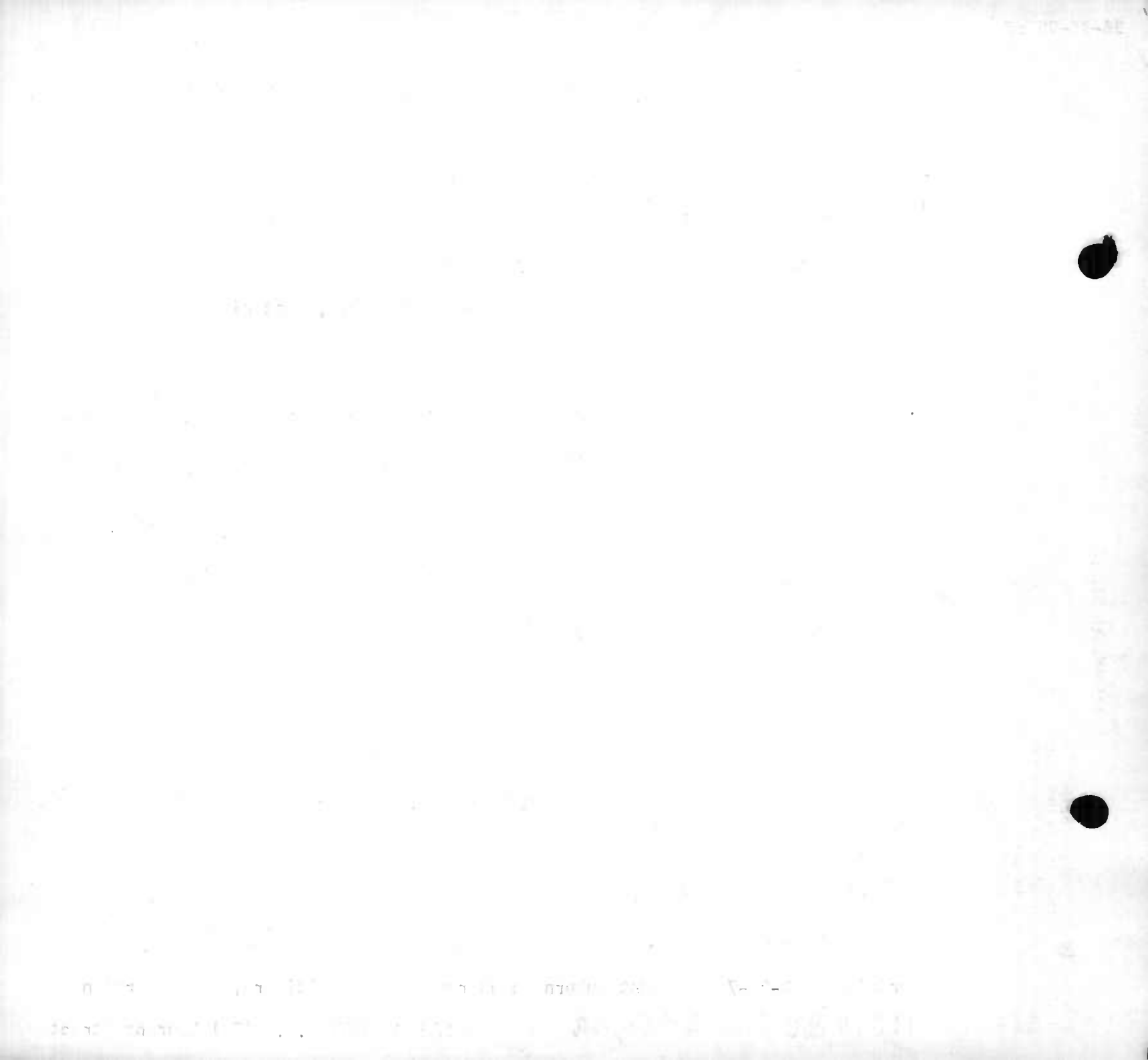
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
70 1999 CERTIFICATE OF DEATH

REG. NO. 70 1999

| | | | | | |
|--|-------------------------|--|-----------------------------------|--|--|
| BIRTH NO. | | 1. NAME OF DECEASED
(Type or Print) <i>James Byrd</i> | | 2. DATE AND HOUR OF DEATH
<i>February 17, 1970 05:00</i> M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>Maryland</i>
B. COUNTY <i>1901</i> | | C. CITY OR TOWN <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>31</i>
<i>BALTIMORE CITY HOSPITALS</i>
<i>4940 Eastern Avenue</i>
<i>Baltimore, Maryland 21224</i> | | D. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | E. STREET AND NUMBER
<i>105 North Mount Street 21223</i> | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>Negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<i>3-2-01</i> | 9. AGE (In years last birthday)
<i>68</i> | 10. Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>North Carolina, Gastonia</i> | |
| 13. FATHER'S NAME
<i>Mitchell (Dec)</i> | | 14. MOTHER'S MAIDEN NAME
<i>Sally (Dec)</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No.</i> | | 16. SOCIAL SECURITY NO.
<i>243-05-0072</i> | | 17. INFORMANT
<i>BCH Records - Baltimore, Maryland 21224</i> | |
| 18. <i>433.9 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
<i>Cardiorespiratory arrest</i>
(B) DUE TO, OR AS A CONSEQUENCE OF:
<i>Left Lower Lobe Pneumonia 3 months</i>
(C) DUE TO, OR AS A CONSEQUENCE OF:
<i>Left middle cerebral artery thrombosis 7 years</i>
<i>ASCD. 14BP.</i>
<i>years.</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>acute</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from <i>January 1st</i> 19 <i>70</i> to <i>Feb. 17</i> 19 <i>70</i> that (X) (we) last saw the deceased alive on <i>February 17</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Francisco Tejada</i> | | 23B. DATE SIGNED
<i>February 17, 1970</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>Francisco Tejada, M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>2-20-70</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Mount Auburn Cemetery</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>FEB 19 1970</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>MORTON & DYETT F.H.</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | | 24E. ADDRESS
<i>4940 Eastern Avenue</i>
<i>BCH</i>
<i>Baltimore, Maryland 21224</i> | | 24F. ADDRESS
<i>1701 Laurens Street</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 70 2000 | | REG. NO. 70 2000 | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. | | | | 70 2000 | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| JAMES DAVID HILL | | | | February 16, 1970 | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE | | B. COUNTY | |
| 00 | | 3408 W. Mulberry Street | | MARYLAND | | 2037 | |
| 5. SEX | | 6. RACE | | C. CITY OR TOWN | | D. INSIDE CITY LIMITS? | |
| Male | | Negro | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. UNDER 1 Yr. Months Days | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 4-8-1930 | | 39 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Carpenter | | | | Baltimore, Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| James Hill | | | | Lydia Hill | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Yes | | | | 8/19/50 12/4/50 | | Mrs. Maggie Hill 3408 W. Mulberry Street | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Acute Myocardial Infarct | | | |
| 19. ANTECEDENT CAUSES | | | | (A) IMMEDIATE CAUSE | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO, OR AS A CONSEQUENCE OF: | | | |
| II | | | | Laennec's Cirrhosis | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | Hours | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At <input type="checkbox"/> Not While <input type="checkbox"/> | | At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 19 68 to Dec 19 69 that (I) (we) last saw the deceased alive on 24 Dec 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Stuart H Brager, MD | | | | 17 Feb 70 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| STUART H BRAGER, MD | | | | 101 E BIDDLE ST | | BALTIMORE MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 2-21-70 | | Mount Auburn Cemetery | | Baltimore, Maryland | |
| 25A. DATE RECD BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| FEB 19 1970 | | Robert E. Taber, MD | | MORTON & DYETT F.H. | | 1701 Laurens Street | |

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